

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Lynn Michele Abbott			2a. DATE OF DEATH Month January , Day 2 , Year 1969			2b. HOUR 2:45a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH January 2, 1969		6. AGE (In years last birthday) 1 YRS. 35 MONTHS 1 DAYS 1 HRS. 35 MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San & Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Va.			13b. COUNTY Lancaster		13c. CITY OR TOWN Weems		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Benjamin Franklin Abbott, Jr.			15. MOTHER'S MAIDEN NAME First Middle Last Gloria Ann Anthony				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Mother Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Secs. 43 mins. Born Premature
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypoxia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-2 , 19 69 , to 1-2 , 19 69 , that (I) (we) last saw the deceased alive on 1-2-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-2-69	
22d. PHYSICIAN'S NAME (Type) N Stoeher, M.D.				22e. ADDRESS 831 University Blvd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1-3-69		23c. NAME OF CEMETERY OR CREMATORY Wash. San & Hospital		23d. LOCATION (City or Town) (County) (State) Takoma Park Montg. Md.	
24. FUNERAL DIRECTOR J.D. Ruffcorn Takoma Park, Maryland				25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00980									
00985					CERTIFICATE OF DEATH				
1. DECEASED-NAME (Type or print) Harold Victor Abercrombie					2a. DATE OF DEATH 1-6-69			2b. HOUR 11:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4-17-94		6. AGE (In years lost birthday) 74		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Office Manager Abercrombie & Co.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8407 16th Street	
14. FATHER'S NAME John George Abercrombie					15. MOTHER'S MAIDEN NAME Sara Jane Bott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 340-07-0265		17. INFORMANT Richard Abercrombie Address Sil. Spr., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Ht Dis 4123 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-4-69 , 19 69 , to 1-6-69 , that (I) (we) lost saw the deceased alive on 1-4-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul D. Cantor					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-6-69		
22d. PHYSICIAN'S NAME (Type) Paul D. Cantor					22e. ADDRESS 4709 Montgomery Lane, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-8-1969		23c. NAME OF CEMETERY OR CREMATORY Darktown Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.			
24. FUNERAL DIRECTOR Clark E. Wigglesworth ADDRESS Sil. Spr. Md. Warner E. Pumphrey, Inc. 8434 Georgia Avenue					25a. REC'D BY REGISTRAR DATE JAN 10 1969		25b. REGISTRAR'S SIGNATURE Richard Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 408 Maryland State Department of Health
1-17-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00986

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00981

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Hally B. Ables						1-4			1969			7:40 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
XXM F	Cau	8/15/95	73 YRS.	MONTHS	DAYS	HOURS	MIN.	1-4-1969			7:40 P.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Texas			U.S.						Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross			Housewife			own home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Montgomery			Sil. Spr.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1801 Sanford Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last			First Middle Last					
Patrick -- Ellard			Alice Renee LeReno											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			219 54 575			Helen A. Driskell, dau			1926 Rosemary Hills Dr. S.S. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Extensive, bilateral, lobular														
DUE TO, OR AS A CONSEQUENCE OF														
(b) Pneumonia														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
		19 P.M.												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		22b. DATE SIGNED		CHIEF MEDICAL EXAMINER <input type="checkbox"/>										
EXAMINER'S NAME (Type)		JAN. 4, 1969		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										
BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
				ADDRESS (City or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)						
Burial		1-8-1969		St. Lincoln Cemetery				Prince Georges, Maryland						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
C. Glen Carter		Sil. Spr., Md.		JAN 13 1969				Charles Judge						
Warner E. Pumphrey, Inc. 8434 Georgia Avenue														

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CERTIFICATE OF DEATH

00982

00987

1. DECEASED NAME (Type or print) <i>Mary Belle</i> First <i>Ahearn</i> Middle Last			2a. DATE OF DEATH Month <i>Jan</i> Day <i>23</i> Year <i>1969</i>			2b. HOUR <i>12 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 30 1900</i>		6. AGE (In years last birthday) <i>68</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Tenn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>8024 Hampden Lane</i>							
14. FATHER'S NAME First <i>Patric</i> Middle <i>Henry</i> Last			15. MOTHER'S MAIDEN NAME First <i>Edna</i> Middle <i>McGweeney</i> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>Leabard Vincent P. Ahearn</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CIRCULATORY COLLAPSE</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>METASTATIC CARCINOMA - LIVER, OVARY</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>PRIMARY CARCINOMA - BREAST</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 HRS</i> <i>2 MONTH</i> <i>8 MONTH</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 12, 1969</i> to <i>JAN 23, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 23 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>L. J. Donovan</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/23/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>DR. L. J. DONOVAN</i>				22e. ADDRESS <i>8215 WILCOX AVE BETHESDA MARYLAND 20814</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. J. J.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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EXHIBIT 100000
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X

MEDICAL CERTIFICATION

00988		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00983					
Items #4, Film G109 1/29/69 km								CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last <i>Ethel Evelyn Alldridge</i>					2a. DATE OF DEATH Month <i>1</i> Day <i>13</i> Year <i>69</i>			2b. HOUR <i>7:50</i> A M			
3. SEX <i>Female</i>		4. RACE <i>American White</i>		5. DATE OF BIRTH <i>3-3-02</i>		6. AGE (In years last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS <i>10</i> DAYS <i>10</i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>American</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash Sen & Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Legal Secretary</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Gov.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Wash D.C.</i>		13c. CITY OR TOWN <i>Wash D.C.</i>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1884 Columbia Rd. N.W.</i>			
14. FATHER'S NAME First Middle Last <i>Heys B Young</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mildred J. Patterson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Chad</i>				Address <i></i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>liver failure</i> <i>1538</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic colorectal carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i></i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>10/19</i> , 19 <i>68</i> , to <i>1/13</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/13</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes noted above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Lewis Hilliard Dennis</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/13/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Lewis Hilliard Dennis, MD</i>		22e. ADDRESS <i>Washington Forestville</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-16-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Epiphany Church Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Forestville Pr. Geo. Md.</i>					
24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home 4308 Suitland Rd. Suitland, Md.</i>						25a. REC'D BY REGISTRAR <i>JA 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		Month Day Year		2b HOUR
WILLIAM PAUL ALLEN						ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>		1-30-69		19 4:55 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR
Male	Cau.	01-25-06	62 YRS					Month 1- Day 30-69 Year 19 4:55 PM		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Texas		U.S.A.				Montgomery Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Wash. San. & Hosp.			Electrician			Union	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			P.G.		Hyatts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1304 Quebec St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Luther M. Allen			Frances J. McCoy							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS		
No			Yes		Mrs. Gloria Allen - Wife			1304 Quebec St. Hyatts., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm										
441.2 DUE TO, OR AS A CONSEQUENCE OF										
(b) with massive hemorrhage										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED	
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, town or county)			JAN. 31, 1969	
Belden R. Reap, MD										
23a BURIAL, CREMATION, or REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial		2-3-1969		St. Lincoln Cemetery			Prince Georges, Maryland			
24. FUNERAL DIRECTOR				ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Gladys J. Smith				Sil. Spr., Md.			FEB 5 1969		William A. Under	
Warner E. Pumphrey, Inc. 8434 Georgia Avenue										



CERTIFICATE OF DEATH

00990

00085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print) Fred			First (None)			Middle Alt			Last			2a. DATE OF DEATH Month January Day 4 Year 1969			2b. HOUR AM 7:40M		
3 SEX Male			4 RACE White			5 DATE OF BIRTH 6 March 1912			6 AGE (In years last birthday) 56 YRS.			7 UNDER YEAR MONTHS 56			8 UNDER 24 HRS. DAYS 56		
7a. BIRTHPLACE (State or foreign country) Austria			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer			12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Res. dence before 1900) Maryland,			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5200 Carlton Street, XXXX					
14 FATHER'S NAME Joseph			First Alt			Last			15 MOTHER'S MAIDEN NAME ELSA Elsa			First Schreier			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) Yes			(If yes give war or dates of service) WW II			16b. SOCIAL SECURITY NO. 060-12-7984			17 INFORMANT Bethesda, Maryland The Medical Records, The Clinical Center.								
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with congestive/ 200X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 2 Years																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street, factory) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (if (this hospital) attended the deceased from 3 December 1968 , to 4 January 1969 , that (a) (we) lost the deceased alive on 4 January 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Martin H. Cohen, MD			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 4 January 1969								
22d. PHYSICIAN'S NAME (Type) Martin H. Cohen, MD.			22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 1-7-1969			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co., Md.								
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016			ADDRESS			25a. REC'D BY REGISTRAR DATE 1-8-1969			25b. REGISTRAR'S SIGNATURE [Signature]								

CA

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00991

00986

1 DECEASED-NAME (Type or print)		First Clara	Middle Hart	Last ANDREWS	2a. DATE OF DEATH January Month 20 Day 69 Year		2b. HOUR 820A M
3. SEX Female		4 RACE Caucasian		5. DATE OF BIRTH Aug. 10, 1876		6 AGE (In years last birthday) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUA. OCCUPAT ON (Kind of work done during most of working life even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last James Paxton Hart		15 MOTHER'S MAIDEN NAME First Middle Last Eliza Jane AIKEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO 559 48 5337B		17 INFORMANT Bethesda Address Md. Mrs. Irene Whyte, 8201 Jefferson Street					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro vascular accident secondary to 4. + DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from Jan. 2, 19 69, to Jan. 20, 19 69, that (X) (we) last saw the deceased alive on Jan. 20, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John A. Routenberg		DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 21, 1969	
22d. PHYSICIAN'S NAME (Type) John A. Routenberg, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-23-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave. Bethesda, Md.				25a. RECEIVED BY REGISTRAR JAN 23 1969 DATE			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First <i>David</i> Middle <i>William</i> Last <i>Anthony</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <i>Jan. 11 1969</i>			2b. HOUR <i>6:50 A.M.</i>		
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>12/27/951</i>	6. AGE (in years last birthday) <i>17</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>		2c. DATE PRONOUNCED DEAD Month <i>Jan</i> Day <i>11</i> Year <i>1969</i>		2d. HOUR <i>6:50 A.M.</i>	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>D.C.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>RFD #2</i>	
14. FATHER'S NAME First <i>David</i> Middle <i>Anthony</i> Last <i>Patricio</i>			15. MOTHER'S MAIDEN NAME First <i>Frank</i> Middle <i>Frank</i> Last <i>Frank</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i></i>			17. INFORMANT <i>Parents -</i>			ADDRESS <i>Home</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe -</i>										<i>3 hrs -</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Trauma from Auto Accident -</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <i>3:45 PM Jan 11 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Lost control driving car hit utility pole.</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f. LOCATION Street or RFD No <i>Route 28 - near - Basisville</i> City or Town <i>Montgomery</i> County <i></i> State <i>Md.</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Jan. 11 1969</i>		
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-15-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington, National</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington Virginia</i>					
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>				ADDRESS <i>7557 Wisconsin Ave Bethesda, Md.</i>				25a. REC'D BY REG. STRAR <i>JAN 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3099J

CERTIFICATE OF DEATH

00388

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
JOHN			THOMAS	ATWOOD	1 Month 17 Day 69 Year			4:45 P M			
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		8/2/96		12 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
MARYLAND		U.S.A.				MONTGOMERY					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
OLNEY		MONTGOMERY GENERAL		RETIRED CABINET MAKER		INDUSTRY			Self-employed		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		MONTGOMERY		KENSINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11025 MADISON STREET			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JAMES			THOMAS	ATWOOD	PEARL			HOWSER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address			
No			214-03-3069		MEDICAL RECORDS			8-5-96			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Myocardial infarction, acute</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 wks.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>53</u> , to <u>Jan 17</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Jan 17</u> , 19 <u>65</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>A.D. Bonifant</u>										1/18/65	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
A.D. BONIFANT						Silver Spring, Md					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
		1-21-1965		Gate of Heaven Cemetery		Silver Spring, Md					
24. FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C. Glen Carter						L. Spr., Md.		JAN 23 1965		[Signature]	
E. P. [unclear], P.O. 131 Georgia Avenue						DATE				6	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) Randell			First Middle Last Somerset Aubinoc			2a. DATE KNOWN OF EST DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year Jan 15 1969			2b. HOUR 11 A M										
3. SEX M.		4. RACE W		5. DATE OF BIRTH Nov. 6, 1909		6. AGE (in years last birthday) 59 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month Jan Day 15 Year 1969		2d. HOUR 11 A M					
7a. BIRTHPLACE (State or foreign country) Wash. DC				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None				12b. KIND OF BUSINESS OR INDUSTRY None							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 5924 Holland Rd.			
14. FATHER'S NAME First Harry S Middle S Last Aubinoc				15. MOTHER'S MAIDEN NAME First Hattie E. Middle E. Last Randall															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO 517-4-0313				17. INFORMANT ADDRESS Marie Aubinoc 5924 Holland Road, Rockville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Injuries-Multiple-Severe-- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Trauma from Auto Accident DUE TO, OR AS A CONSEQUENCE OF (c) Rupture of Aneurysm of Abdominal Aorta. 24hr. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden.																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 11 AM Jan 15 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) While driving car-fainted+car struck a pole											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street				21f. LOCATION Street or R.F.D. No 6200 block of Tilden City or Town Rockville County Mont. State Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE John G. Ball				EXAMINER'S NAME (Type) John G. Ball, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Jan 15, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 1-20-1969				23c. NAME OF CEMETERY OR CREMATORY Parlman Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.							
24. FUNERAL HOME OR ADDRESS Funeral Home of S. N. White, 2001 13th St. N.W., Washington, D.C.				25. REC'D BY REGISTRAR JAN 23 1969				25b. REGISTRAR'S SIGNATURE James J. Judge											

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00990

1 DECEASED NAME (Type or Print) First Middle Last Joseph Edward Bartley			2a DATE KNOWN OF DEATH Month Day Year 2 21 19 69			2b HOUR 12 50 PM		
3 SEX Male	4 RACE Cauc	5 DATE OF BIRTH 7/23/47	6 AGE (in years last birthday) 21 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 2 1 19 69		
7a BIRTHPLACE (State or foreign country) Wash D C		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Const. Firm, Chem. Co.			12b KIND OF BUSINESS OR INDUSTRY Const. Firm, Chem. Co.
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE MD		13b COUNTY Mont		13c CITY OR TOWN Sil. Spg.		13d INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 10205 Proctor St.
4. FATHER'S NAME First Middle Last Frank Edward Bartley				15. MOTHER'S MAIDEN NAME First Middle Last Helen Marie Zimmerman				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) YES		(If yes give war or dates of service) Viet Nam		16b SOCIAL SECURITY NO 219-46-8863		17. INFORMANT Mrs. Helen Gussin ADDRESS 43 a, b, c, Joseph S. Hoover 3221 Military Rd.		
18 CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c)) - PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) incurred in auto accident DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 11 30 PM 11-31-69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 2 unless 18a)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No City or Town County State Norbeck Rd. Silver Spring Montgomery Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Beap		EXAMINER'S NAME (Type) BELDEN R. BEAP M.D.		CHIEF MED CAL EXAMINER <input type="checkbox"/> ASS STANT MED CAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 1, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave. Silver Spg.				25a. REC'D BY REGISTRAR FEB 7 1969		25b. REGISTRAR'S SIGNATURE M. J. ...		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

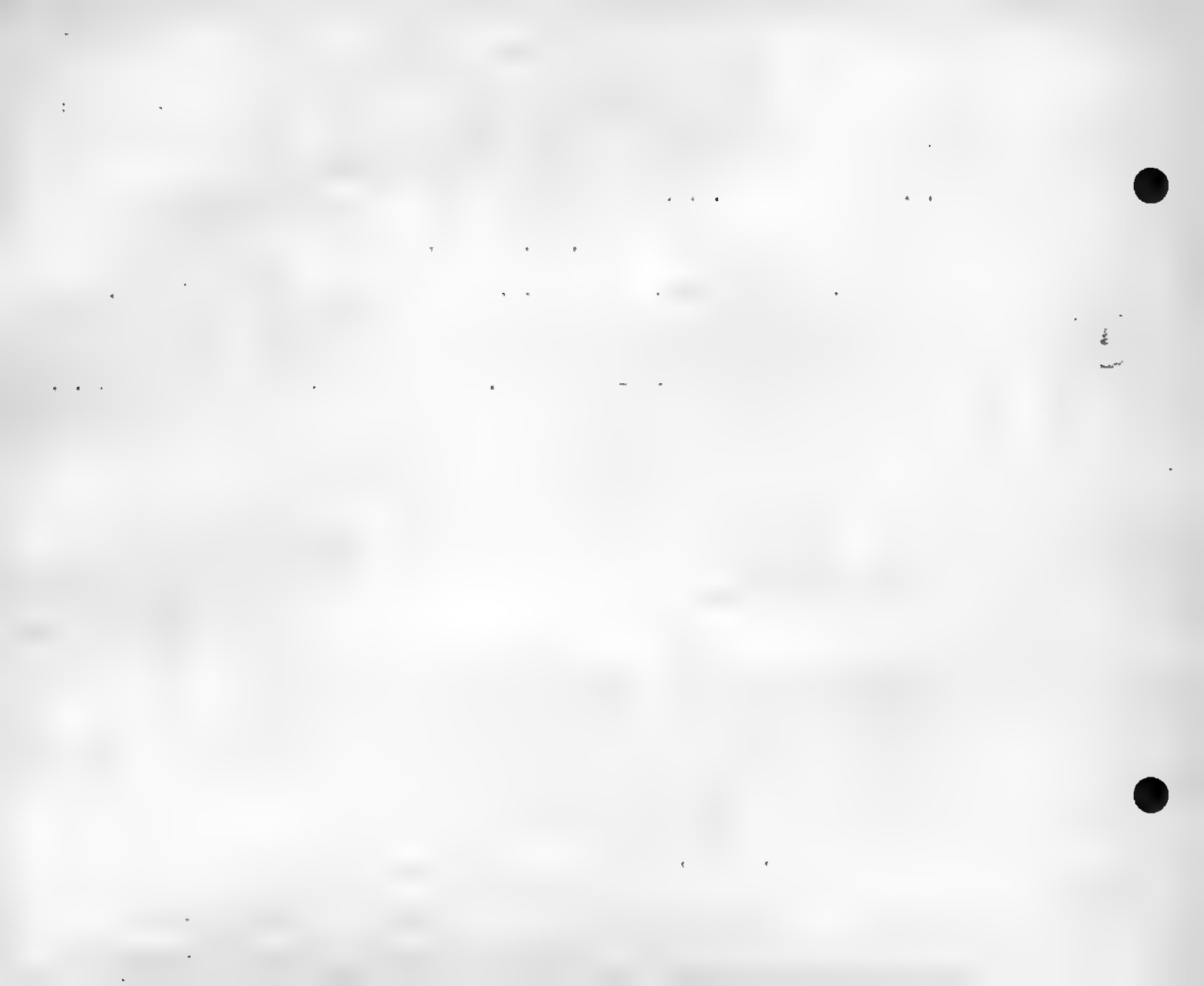
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00992

00996

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) CLARA LEACH BATEMAN			First Middle Last			2a. DATE OF DEATH Month Day Year 1-12-69			2b HOUR 9:20p		
3 SEX Female			4 RACE White			5. DATE OF BIRTH 3-15-93			6 AGE (In years last birthday) 75 YRS		
7a. BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, † institution. Res. dence before admission) STATE Md.			13b COUNTY Mont.			13c CITY OR TOWN S.S.			3d. INSIDE CITY, AM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 106 Franklin Ave.			14 FATHER'S NAME First Middle Last Edward Scott Morgan			15 MOTHER'S MAIDEN NAME First Middle Last Ida Rebecca Ewing					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown None			(If yes give war or dates of service) --			16b SOC AL SECURITY NO. 577-10-6814			17 INFORMANT Address Mrs. Minnie Glorius, 1000 East-West Hy, T.P., Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 436.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 days years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Sensitivity											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street factory) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Apr. 27, 1968 to Jan 12, 1969 , that (I) (we) last saw the deceased alive on Jan 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.											
22b. SIGNATURE Philip E. Jones M.D.						DEGREE M.D.			22c. DATE SIGNED 1-12-69		
22d. PHYSICIAN'S NAME (Type) Philip E. Jones, MD						22e. ADDRESS 500 Parkview Drive Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1-15-1969			23c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, D.C. 1131 Georgia Ave. N.W.						25a. REC'D BY REGISTRAR JAN 20 1969			25b. REGISTRAR'S SIGNATURE James J. Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Case closed with Dr. Ball

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item 16 Film G408 1/14/69 kk

C0882

1 DECEASED NAME (Type or print) First Georgie Middle Mae Last Batton		2a. DATE OF DEATH Month Jan Day 11 Year 1969		2b. HOUR 12:30 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH August 26, 1909	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10305 Insley St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Telephone op.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First John Middle F. Last Nash		15 MOTHER'S MAIDEN NAME First Bertha Middle Myers Last Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 223--03-5953		17 INFORMANT Address Hazel Heaton, Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Generalized atherosclerosis with coronary artery sclerosis (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11-15-1968 to 11-18-68 , that (I) (we) last saw the deceased alive on 11-18-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and not) view the body after death					
22b. SIGNATURE C. P. Ryland		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1-11-69	
22d. PHYSICIAN'S NAME (Type) C. P. RYLAND		22e. ADDRESS 4400-49 8th Ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/14/69		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
24 FUNERAL DIRECTOR Joseph Gawler's Sons., 5130 Wis. Ave. N.W. Wash D.C.		ADDRESS		25a. REC'D BY REGISTRAR JAN 15 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]	
23d. LOCATION (City or Town) (County) (State) Fredericksburg, Va.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

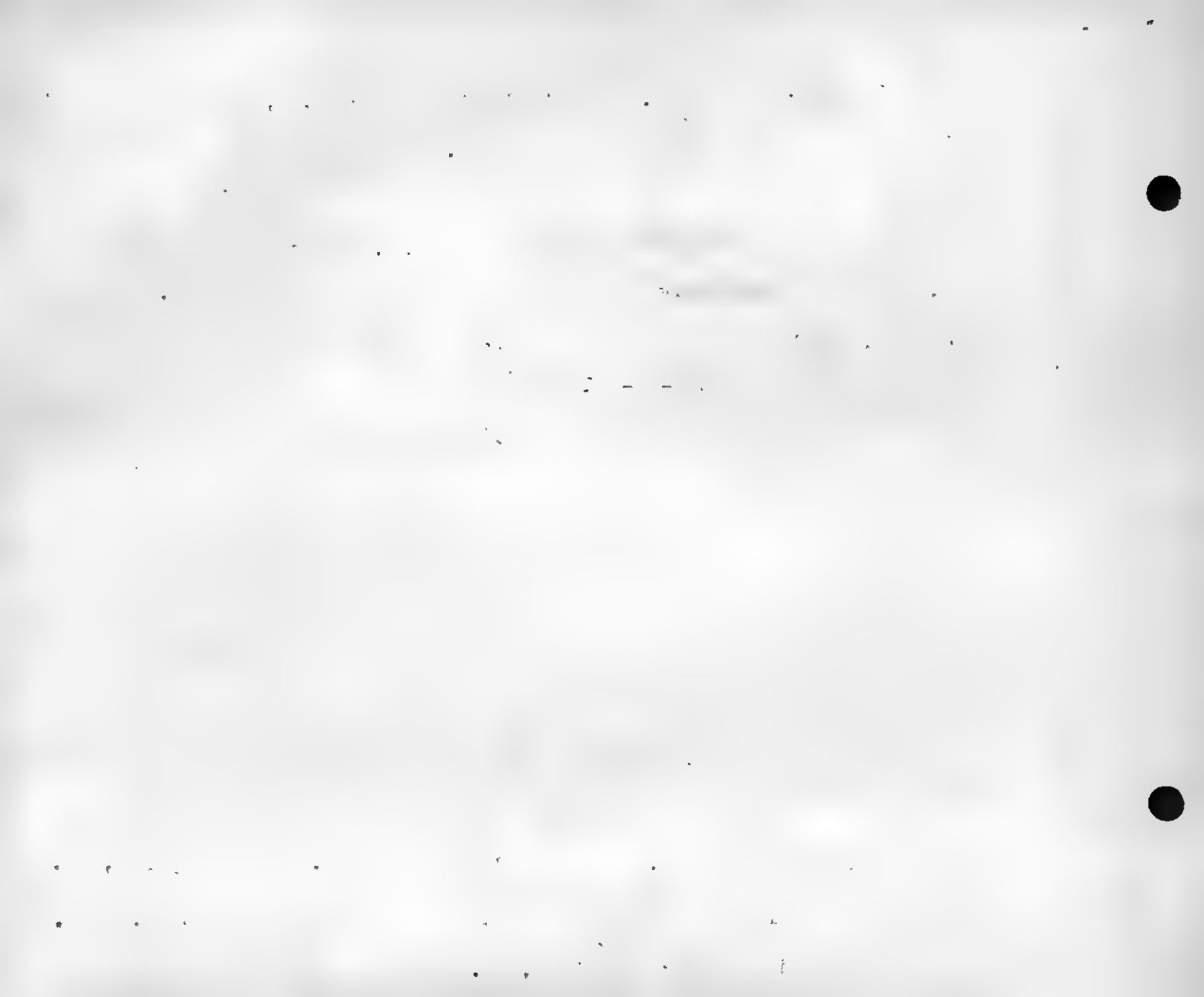
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
20993 Beagle Walter											
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Walter G. Beagle						1 Month 18 Day 69 Year			3:45 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
M		W		1/26/1885		83 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia			U.S.						Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross			CARPENTER					
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Wash. D.C.			Wash. D.C.						339 Cedar St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
ISSAC			BEAGLE			SUSAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			228 18 0340			Mrs. Allen G. Beagle			339 Cedar St NW		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage										12 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure										3 days.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Bronchopneumonia 1 wk.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (1) (this hospital) attended the deceased from Jan 10, 1969, to Jan 17, 1969, that (1) (we) last saw the deceased alive on Jan 17, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did/did not) view the body after death.											
22b. SIGNATURE James R. Coleman MD						22c. DATE SIGNED Jan 19, 1969					
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN MD						22e. ADDRESS 9241 COLUMBIA BLVD			SILVER SPRING, MARYLAND		
23a. BLR AT CREMATION REMOVAL (Specify)			23b. DATE Jan 20, 1969			23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Proppert Virginia		
Buried											
24. FUNERAL DIRECTOR Arthur Walters						25a. JAN 22 1969			25b. REGISTRAR'S SIGNATURE		
254 Carroll St. N.W. Washington, D.C. 20012											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) WILLIAM L. MAXX BEALL					2a. DATE OF DEATH Jan. 4, 1969			2b. HOUR 3:28 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 13, 1881		6. AGE (in years last birthday) 87 YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) Washington Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 105 Luckett St.	
14. FATHER'S NAME William V. Beall				15. MOTHER'S MAIDEN NAME Mary Purdum					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown		16b. SOCIAL SECURITY NO 578-42-1729		17. INFORMANT Millard Beall		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic heart disease 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 68 , to 1/4 , 19 69 , that (I) (we) last saw the deceased alive on 1/4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Bloom MD.				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/4/69	
22d. PHYSICIAN'S NAME (Type) Joseph Bloom MD.		22e. ADDRESS 1111 Spring St. Silver Spring, Md.							
23a. BURIAL, CREMATION, or other (Specify) Burial		23b. DATE 1/8/1969		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		1331 R. ADDRESS Rockville Pike		25a. REC'D BY REGISTRAR DATE JAN 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Richard Middle Jasper Last Beasley			2a. DATE OF DEATH		2b. HOUR	
						Month Jan. Day 20 Year 1969		2:20 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		2-4-83		85 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ark.		Amer.				Montgomery County		Mo	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR IND. STRY			
Takoma Park		Washington San. & Hosp.		retired		Cabinet maker			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - H. 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Montgomery		Silver Spring				2818 Henderson Ct.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First William Middle -- Last Beasley			First Ada Middle unknown Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			579-44-3493		Silver Spring, Md. Mrs Carl Zager, 2818 Henderson Ct.				
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Gram Neg. Septicemia								2 days	
DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACTS INFECTION								10 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary incontinence								3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Gun adreno-schistosom. decreased kidney function									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		Hour A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-4-69, to 1-20-69, that (I) (we) last saw the deceased alive on 1-19-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE									
John L Ford MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>									
22c. DATE SIGNED 1-20-69									
22d. PHYSICIAN'S NAME (Type) JOHN L. FORD M.D. 22e. ADDRESS 831 UNIVERSITY BLVD. E. SILVER SPRING MD 20903									
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan 22, 1969		Pine Grove		Mt. Airy, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Olin L. Molesworth, Damascus, Md.					JAN 23 1969				

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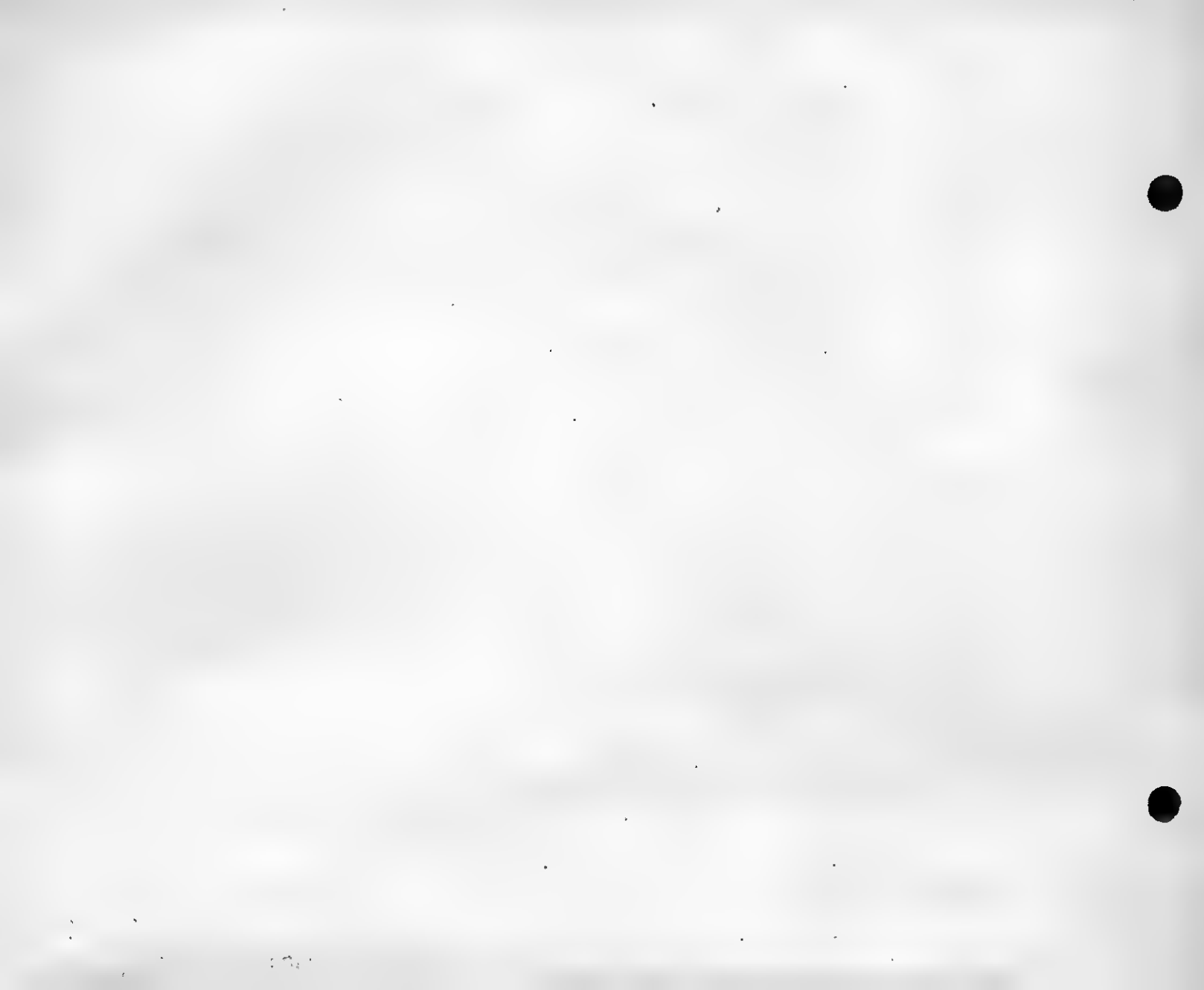
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0100.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00996

1 DECEASED-NAME (Type or print) First Middle Last <u>Irene BELLE Benjamin</u>			2a DATE OF DEATH Month <u>13</u> Day <u>19</u> Year <u>69</u>		2b HO JR <u>3-05</u> M
3 SEX <u>F</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>5-5-95</u>	6 AGE (in years last birthday) <u>73</u> YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTH-PLACE (State or foreign country) <u>Mich</u>	7b CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Montgomery</u> Md		
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Washington Sanatorium</u>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Host.</u>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Silver Spring</u>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <u>3452 Cheswick Court.</u>
14 FATHER'S NAME First Middle Last <u>Spence</u>		15 MOTHER'S MAIDEN NAME First Middle Last <u>Abigail Anglen</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service) <u>NO</u>		16b SOCIAL SECURITY NO <u>220-34-4456</u>		17 INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the breast</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>WKS.</u> <u>MOS.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1968</u> , to <u>JAN. 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>JAN. 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Albert H. Grollman</u>		22c DATE SIGNED <u>1/13/69</u>		22d PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>	
22e ADDRESS <u>1106 S PRING ST. SILVER</u>					
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial Jan. 1969</u>		23b DATE		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d LOCATION (City or Town) (County) (State) <u>Colmar Manor Pk. Md.</u>					
24 FUNERAL DIRECTOR <u>Arthur Waters</u>		25a REC'D BY REGISTRAR <u>254 Genl. St. W. D.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared with Medical Examiner Dr. [illegible]

0100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00997

Registration of Births and Deaths

CERTIFICATE OF DEATH

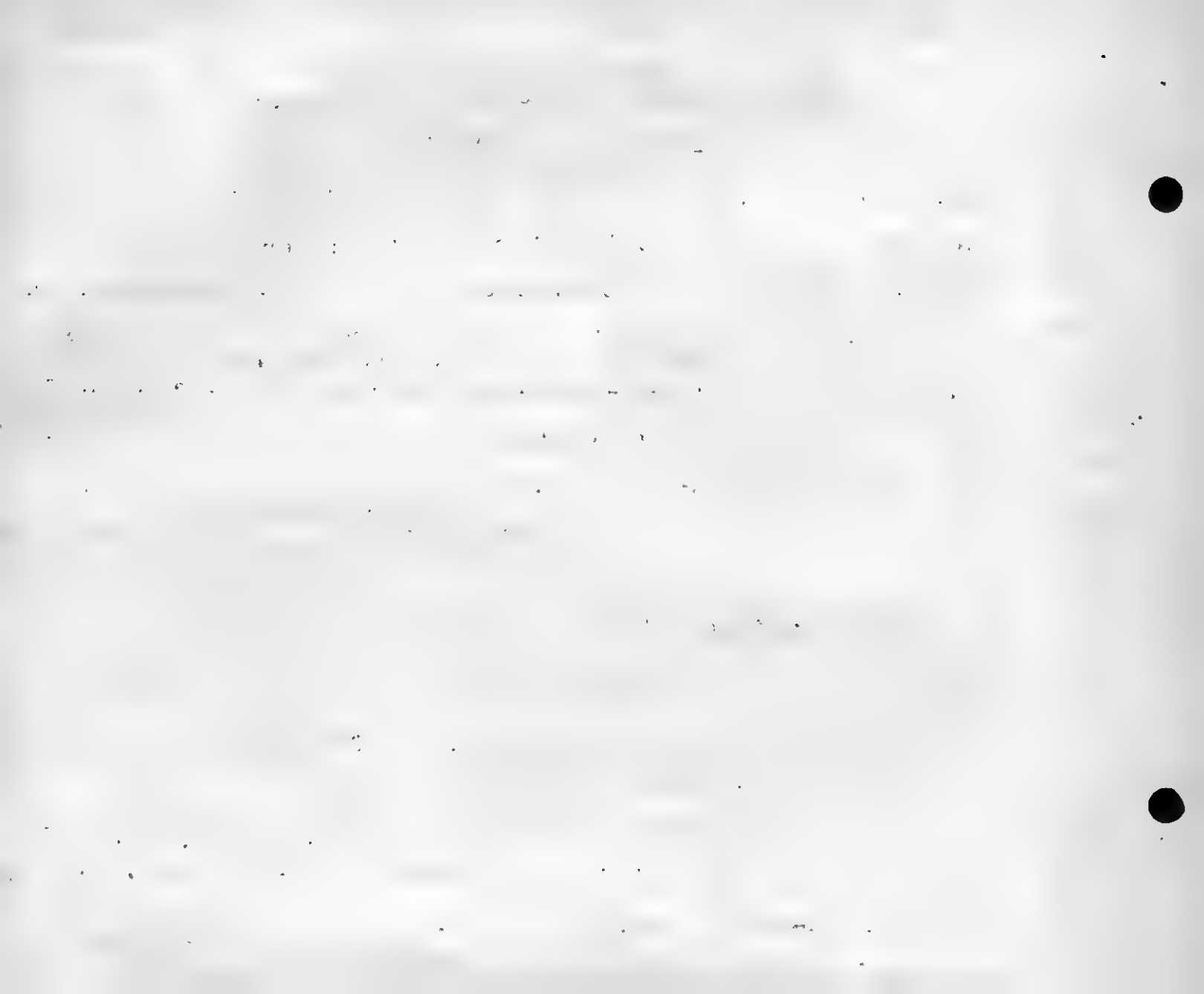
DECEASED NAME (Type or print) First Middle Last Emma FRANCES Bennett			2a. DATE OF DEATH Month Day Year 1 11 69			2b. HOUR 545A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 6/17/85		6. AGE (In years last birthday) 83 YRS	
7a. BIRTHPLACE (State or foreign country) NY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Park Haven Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6113 St., NW		13f. CITY Takoma Park		13g. ZIP CODE 20912		13h. PHONE 246-1234	
14. FATHER'S NAME First Middle Last Henry Bricker Cooley			15. MOTHER'S MAIDEN NAME First Middle Last Lyleon Hart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) unknown		17. INFORMANT Address Nursing Home Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic Cardiovascular Renal Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yrs</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>1/11/69</u> , that (I) (we) last saw the deceased alive on <u>12/21/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>P. Cooley M.D.</u>		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/11/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>P. Cooley MD</u>		22e. ADDRESS <u>3737 Legation St NW DC 20015</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>1/11/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Belts Mount Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		ADDRESS <u>Washington, DC 20015</u>		25. REC'D BY REGISTRAR <u>DATE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Grace	Middle (NMN)	Last Bennett	2a. DATE OF DEATH Month January Day 4 Year 1969		2b. HOUR A.M. 10:20 M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3 May 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired: Secretary		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission to hospital) Florida				13b. COUNTY Daytona Beach		13c. CITY OR TOWN Daytona Beach		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First John Middle Last Bennett				15. MOTHER'S MAIDEN NAME First Dorcas Middle Last Grimes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 162-16-0773		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism 180 x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombosis of Left Hypogastric Vein DUE TO, OR AS A CONSEQUENCE OF Total Pelvic exenteration (5 days) (c) for recurrent Carcinoma Cervix								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Days 1 Year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 12/31/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Cervix			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I (this hospital) attended the deceased from 24 Nov. , 19 68 , to 4 Jan. , 19 69 , that we (we) last saw the deceased alive on 4 January , 19 69 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, we (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter J. Deckers MD DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 January 1969		
22d. PHYSICIAN'S NAME (Type) Peter J. Deckers, M.D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-7-69		23c. NAME OF CEMETERY OR CREMATORY Green County Mem. Park		23d. LOCATION (City or Town) (County) (State) Jefferson, Penna.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR 9 1969		25b. REGISTRAR'S SIGNATURE John A. Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01004 CERTIFICATE OF DEATH 00999									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
ISABEL JANE BENTON						1-31-69		9:40p.M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		11-3-05		63 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Oregon		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Wsh. San. & Hos.			RN		WSH	
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.			P.G.			Chillum		6500 Knollbrook Dr.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William C. Young			Mary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
None						Mr. Grant Benton - Husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 582X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) <u>Hypertensive heart disease - hard S.C.</u> stating the underlying cause (c) <u>Chronic severe glomerulonephritis</u> lost. <u>old.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1952 to 1/31/69, that (I) last saw the deceased alive on 1/16/69, and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) last (did) last view the body after death.									
22b. SIGNATURE <u>Ernest A. Sarao</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/31/69		
22d. PHYSICIAN'S NAME (Type) ERNEST A. SARAO					22e. ADDRESS New Hampshire Ave Tak Park Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 4. 1969		Parklawn Cemetery		Rockville Md			
24. FUNERAL DIRECTOR <u>Barrell & N.W.</u>					25a. FILED BY REGISTRAR DATE FEB 3 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year		2b HOUR
David Shay Berman						Month 1 Day 24 Year 1969			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR		
Male	Cauc	11/9/07	61 YRS	MONTHS	DAYS	Month 1 Day 24 Year 1969			16:46 M		
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
N.Y. N.Y.		USA				Montgomery					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hosp.			Hair Stylist					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Montgomery			Sil.Spg.			11491 Columbia Pike		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
PESACH			Berman			HANNAH					
17 INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
wife			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Paula Berman			DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Artery Heart Disease</u>								
11491 Col. Pike S.S.			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER					
BELDEN R. REAP, M.D.			ADDRESS (Street, city, town or county)			JAN. 24, 1969					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
JAN. 26, 1969			JAN. 26, 1969			KING DAVID MEM. GARDEN			FALLS CHURCH, VA.		
24 FUNERAL DIRECTOR			ADDRESS			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
BERNARD DANZANSKY & SONS			3501-14th St N.W. WASH, DC			DATE JAN 29 1969			J. Charles Judge		

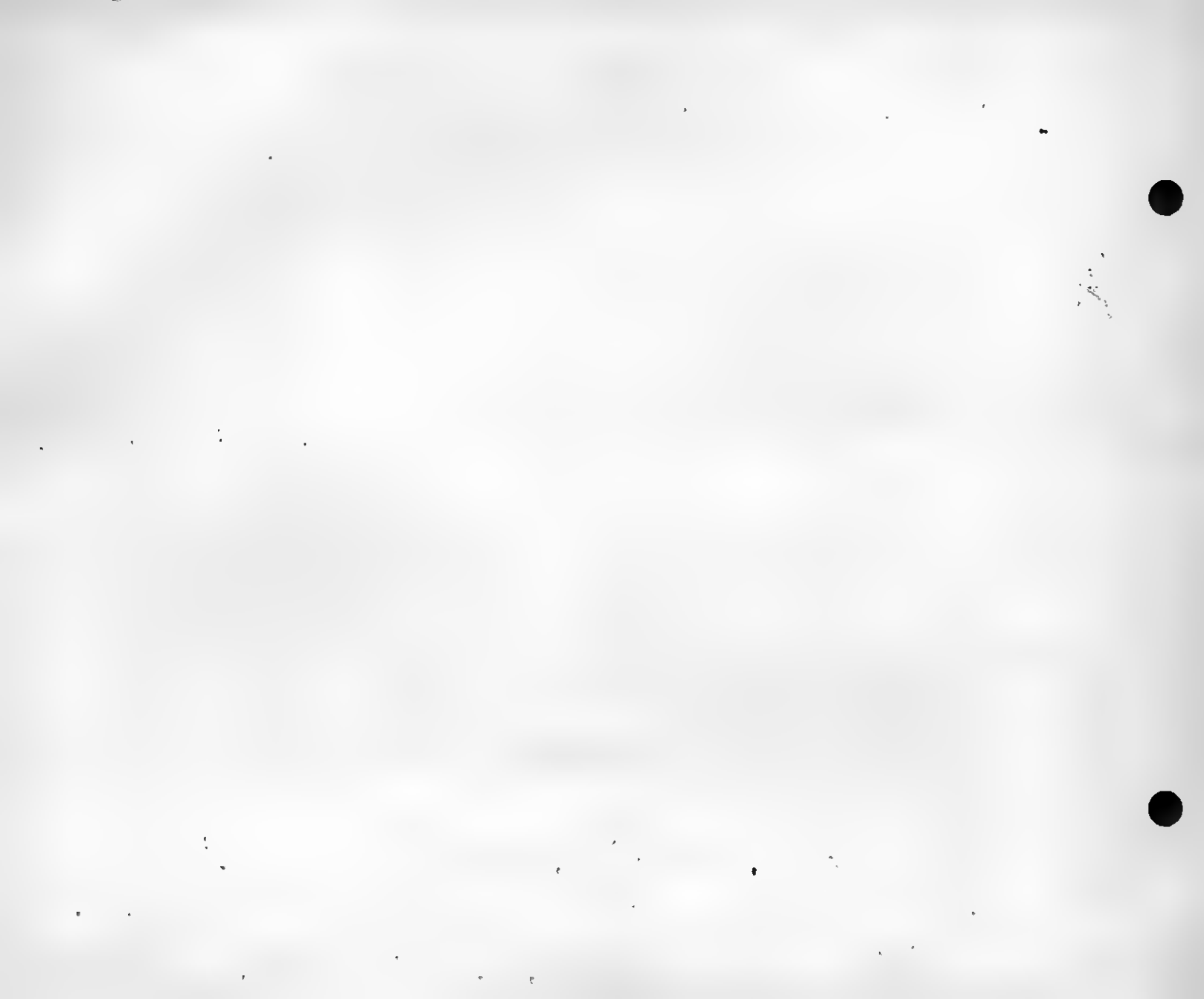


FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
ALayde Cunha Bittencourt						Month Day Year			10 50 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD			2d HOUR
7c	W	June 19-1967	61 YRS					Month Day Year			11 51 M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Brazil			Brazil						Montgomery Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban								
13a USUAL RESIDENCE (Where deceased lived, if institution admiss on) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY: M 15?		
Rie Brazil			Niteroi			Niteroi			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
Rawl DeFaria Cunha			Amelia								
17 INFORMANT			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
San Antonio			Rockville Md.			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			15 min.		
Plinio - Villela - 12111 Lauderdale Drive -						(b)			years		
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A M P M 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f LOCATION Street or R F D No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
John G. Ball			7936 Old Georgetown Road			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Jan. 18, 1969.		
John G. Ball Bethesda, Maryland			ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			1/21/69			Gate of Heaven Cemetery			Silver Spring, Md.		
24 FUNERAL DIRECTOR			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Tyson Wheeler Funeral Home 1331 Rockville Pike			DATE			JAN 21 1969			Charles Judge		
Rockville, Md.											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

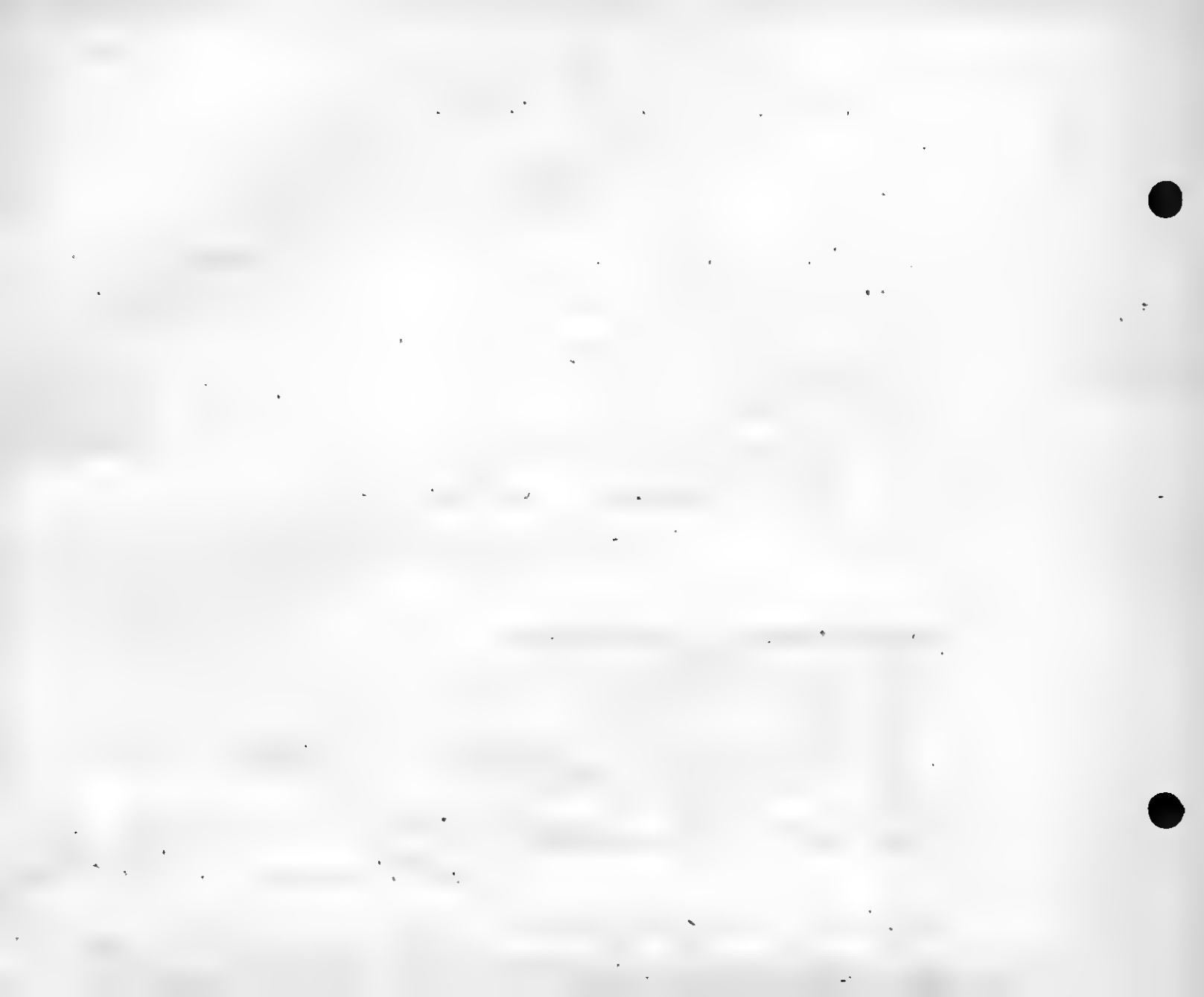
CERTIFICATE OF DEATH

21002

1. DECEASED-NAME (Type or print) First Middle Last CARROLL D Blakey			2a. DATE OF DEATH Month Day Year 1 30 69			2b. HOUR 10⁰⁵ AM	
3. SEX m		4. RACE w		5. DATE OF BIRTH 3-27-36		6. AGE (In years last birthday) 32 YRS	
7a. BIRTHPLACE (State or foreign country) Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH MONTGOMERY CO.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unemployed		12b. KIND OF BUSINESS OR INDUSTRY Painting	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8701 BRADFORD Rd.							
14. FATHER'S NAME First Middle Last James W. Blakey			15. MOTHER'S MAIDEN NAME First Middle Last Elsie Mae				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Everett E. Blakey, 704 McNeil St Harpersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Chronic intoxication DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 96 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 1/27/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding esoph. Varices		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 16 Jan , 19 69 , to 20 Jan , 19 69 , that (I) (we) last saw the deceased alive on 19 Jan , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph F. Schanno MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 20 Jan 69	
22d. PHYSICIAN'S NAME (Type) Joseph F. Schanno		22e. ADDRESS 8218 Hesperian Ave Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 22, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor B. Geo. Md	
24. FUNERAL DIRECTOR Arthur J. Vatter		ADDRESS 254 Carroll St NW Wash DC		25a. REC'D BY REGISTRAR JAN 23 1969		25b. REGISTRAR'S SIGNATURE James J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR 15
45M 69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last MOZELL B. BLAKEY			2a. DATE OF DEATH Month Day Year JAN 25 69			2b. HOUR Min 0845				
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MAR 24, 00		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Rochester, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) CARRIAGE HILL E.C.A.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unemployed		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm. on) STATE D.C.			13b. COUNTY D.C.		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 74 R STREET NW	
14. FATHER'S NAME First Middle Last William Rainey			15. MOTHER'S MAIDEN NAME First Middle Last Freemester, Molly Rainey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO 578-18-3434-A		17. INFORMANT E.B. King		Address 709-21st St. N.W.			
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, colon, metastatic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES, MELLITUS - ADULT ONSET, HYPERTENSION										
19a. DATE OF OPERATION APPROX FEB 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA, COLON			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NA			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR OCCURRING WHILE AT WORK (If either, notify medical examiner) NA		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year NA		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) NA						
21d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> While not at work <input type="checkbox"/>		21e. INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) NA		21f. LOCATION Street or R.F.D. No. City or Town County State NA						
22a. I certify that (1) (this hospital) attended the deceased from 11 DEC , 19 68 , to 25 JAN , 19 69 , that (1) (we) lost saw the deceased alive on 24 JAN , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Donald B. Doty					22c. DATE SIGNED 25 JAN 69		22d. PHYSICIAN'S NAME (Type) DOTY, DONALD B.			
22e. ADDRESS 1909 HANOVER, SILVER SPRING										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/29/69		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery Maryland		23d. LOCATION (City or Town) (County) (State) MD				
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Road N.E.					25a. REGISTRAR'S SIGNATURE Stewart		25b. REGISTRAR'S SIGNATURE Stewart			



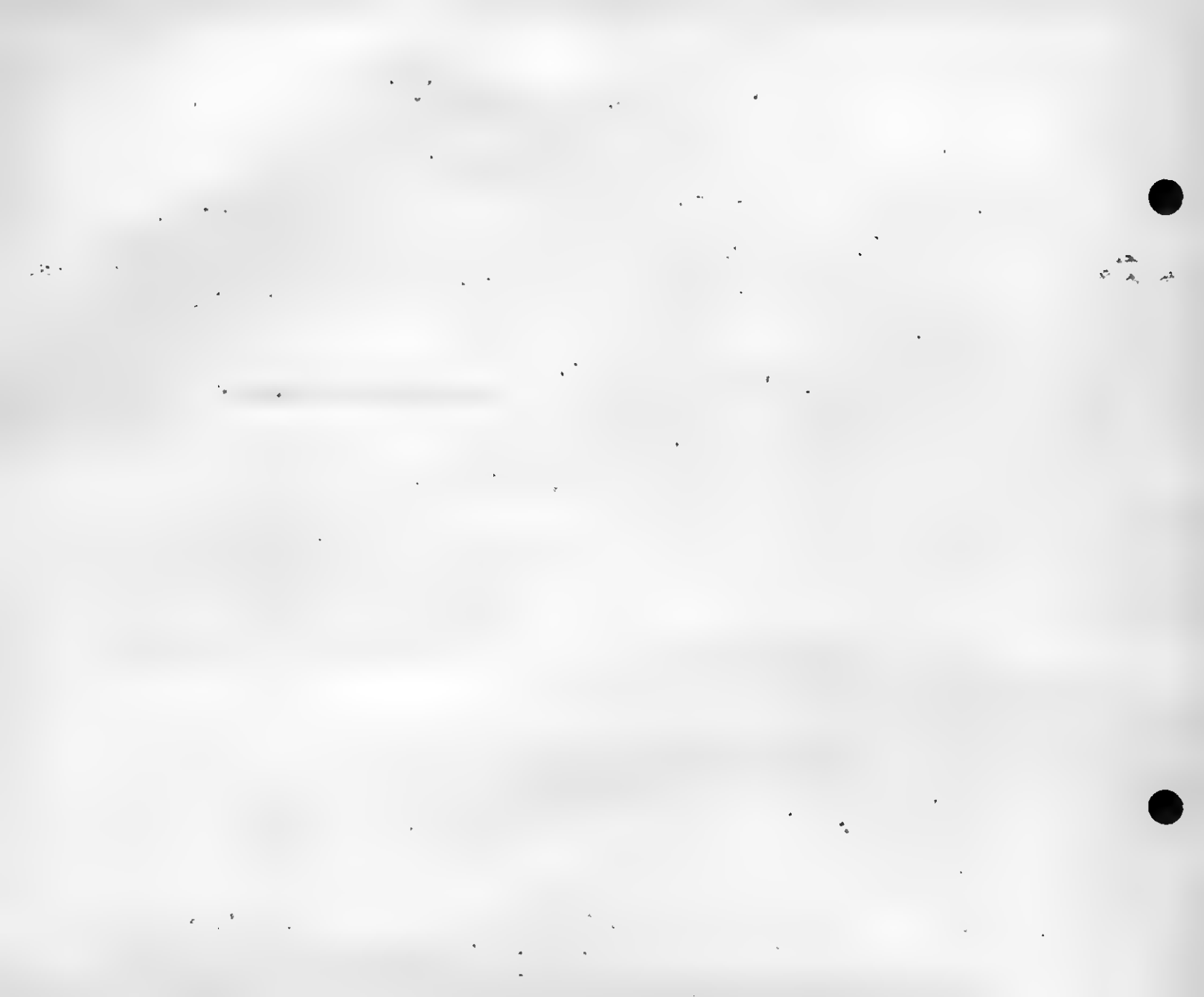
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last FLOYD Jasper BLARELY			2a. DATE OF DEATH Month Day Year 1 16 69			2b. HOUR 5:30 P M	
3. SEX M		4. RACE white		5. DATE OF BIRTH 8-16-83		6. AGE (in years lost birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH SAN & HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if in institution or residence before admission) STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12345 Ardmore Ave		14. FATHER'S NAME First Middle Last Flemming -- Blarely		15. MOTHER'S MAIDEN NAME First Middle Last Maetha Rannable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or date of service) None		16b. SOCIAL SECURITY NO 111-11-1111		17. INFORMANT Blarely		Address 1010 1st St. N.W. Washington, D.C. 20004	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract obstruction CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) CA prostate & pelvic + bony metastases							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1968 to Jan 16, 1969 , that (I) (we) last saw the deceased alive on Jan 16, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benne H. Bandler M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 17, 1969	
22d. PHYSICIAN'S NAME (Type) Benne H. Bandler, M.D.				22e. ADDRESS 1010 1st St. N.W., Washington, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-20-1969		23c. NAME OF CEMETERY OR CREMATORY Viola Cemetery		23d. LOCATION (City or Town) (County) (State) Viola, Maryland	
24. FUNERAL DIRECTOR James E. P. Phipps, Jr. ADDRESS 5534 Georgia Avenue				25a. REC'D BY REGISTRAR JAN 23 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

31010

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

31005

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) BERTHA Centanni Bockholt			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan Day 12 Year 1969			2b HOUR 11:30 AM		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 7-17-1876	6 AGE (in years last birthday) 92 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month Jan Day 12 Year 1969		
7a BIRTHPLACE (State or foreign country) Ill.		7b CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Ohio			13b COUNTY Cincinnati		13c CITY OR TOWN Cincinnati		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME John			15 MOTHER'S MAIDEN NAME Elizabeth			13e STREET AND NUMBER 3425 Michigan Ave		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO 288-09-7104D		17 INFORMANT Grace Eliz. Bockholt, Dtr.			ADDRESS 3425 Michigan Ave. Cinn., Ohio
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute - DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease - DUE TO, OR AS A CONSEQUENCE OF (c) Sudden - conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last years -								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of Rt Hip.								
19a DATE OF OPERATION Jan - 6, 1969.			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Repair of fracture of Rt hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year Jan 5 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Fall on floor causing fracture of Rt hip				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No 5813 Norbury Rd. City or Town Bethesda County Montgomery State MD.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED Jan 13, 1969		
EXAMINER'S NAME (Type) John G. Ball, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 1/16/69		23c NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d LOCATION (City or Town) (County) (State) Fort Mitchell, Kentucky	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, D. C.			ADDRESS Washington, D. C.			25a REGD. BY REGISTRAR JAN 15 1969		25b REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												C1006		
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year			2b. HOUR	
FRANK - BRACEY										January 31 69			10:15 AM	
3. SEX M		4. RACE NEGRO		5. DATE OF BIRTH 11-1-1894 1911			6. AGE (In years, last birthday) 57-73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) S. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.							
10. CITY OR TOWN OF DEATH WHEATON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.			13b. COUNTY WASHINGTON			13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1040 6th St, N.E.				
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Deceased Address								
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u>												1 hr.		
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.												5 yrs.		
(b) <u>arteriosclerotic cardiovascular disease</u>														
(c) <u>dissecting</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>68</u> , to <u>1/31</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Myron L. Lenkin</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type) <u>Myron L. Lenkin</u>				22e. ADDRESS <u>Wheaton, Md.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Macodinia Baptist</u>				23d. LOCATION (City or Town) (County) (State) <u>Westville, S.C.</u>						
24. FUNERAL DIRECTOR <u>R.N. Horton</u>				Co. <u>1324-U St. N.W.</u>				25a. REC'D BY REGISTRAR <u>FEB 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>1976 Lenkin</u>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																															
CERTIFICATE OF DEATH																															
1. DECEASED NAME (Type or print)			First BEULAH			Middle LEE			Last BROWN			2a. DATE OF DEATH Month 1			Day 11			Year 69			2b. HOUR 5:20			a M							
3. SEX Female			4. RACE White			5. DATE OF BIRTH 9-5-94			6. AGE (in years lost birthday) 74 YRS			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			HOURS			MIN										
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.																						
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY																						
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Box 568A																			
14. FATHER'S NAME First Oliver			Middle L.			Last Brown			15. MOTHER'S MAIDEN NAME First Annie			Middle Hill			Last Hill																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 212 34 5214			17. INFORMANT Medical Records			Address Montgomery General Hospital			Olney, Md.																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD & severe angina pectoris</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myxedema and hypercholesterolemia</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 mos. 6 mos +													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF FATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																									
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1968, to <u>Jan 11</u> , 1969, that (I) (we) lost saw the deceased alive on <u>Jan 10</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																															
22b. SIGNATURE <u>Frederick Moomau, MD</u>																		DEGREE ATTENDING PHYS			<input checked="" type="checkbox"/> MED DIRECTOR			<input type="checkbox"/> STAFF PHYS			22c. DATE SIGNED <u>Jan. 11, 1969</u>				
22d. PHYSICIAN'S NAME (Type) Frederick Moomau, MD																		22e. ADDRESS Medical Center, Sandy Spring, Md.													
23a. BURIAL, CREMATION, REMOVAL <u>Funeral</u>			23b. DATE 1/14/69			23c. NAME OF CEMETERY OR CREMATORY Linthicum Chapel			23d. LOCATION (City or Town) (County) (State) Clarksville, Howard, Maryland																						
24. FUNERAL DIRECTOR Higinbotham Slack																		ADDRESS Ellicott City, Md.			25a. DEATH REGISTRATION DATE			25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A1-1
30M REV. 1/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1068

1 DECEASED-NAME (Type or print) First Middle Last <i>Gertrude A. Brown</i>			2a. DATE OF DEATH Month Day Year <i>1 17 69</i>			2b. HOUR <i>4:35 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>4/20/01</i>		6 AGE (In years last birthday) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Florat</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>P.B. Md. S.S.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>301 Univ. Blvd. E</i>	
14 FATHER'S NAME First Middle Last <i>Jacob F. Larson</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna L. Anderson</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		(If yes give war or dates of service) <i>577-16-6876</i>		16b. SOCIAL SECURITY NO. <i>577-16-6876</i>		17. INFORMANT Address <i>Mrs. Mildred L. King, 119 River St. Springfield</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>155.0</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> <i>9 mo.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from <i>Jan. 17, 1969</i> , to <i>Jan. 17, 1969</i> , that (1) (we) last saw the deceased alive on <i>Jan. 17, 1969</i> , and that in (my) (our) apian death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James R. Coleman MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Jan. 17, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN MD</i>				22e. ADDRESS <i>9241 COLUMBIA BLVD SILVER SPRING MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Jan. 21, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i>		23d. LOCATION (City or Town) (County) (State) <i>Adephre Pr. Geo. Md.</i>			
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St. Wash DC</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James R. Coleman</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>James M. Brown</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>69</i>			2b. HOUR <i>12:35</i> M				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>4-5-1913</i>		6. AGE (In years last birthday) <i>55</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Service Station Att.</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Mont. Rockville</i>			13c. INS DE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER <i>721 Monroe ST.</i>	
14. FATHER'S NAME First Middle Last <i>James M. Brown</i>			15. MOTHER'S M A D E N NAME First Middle Last <i>Elma Bledsoe</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>224-18-7872</i>			17. INFORMANT <i>Wife - Geraldine - Same</i> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE Cause (a) <i>Myocardial Infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <i>ASHD</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 yrs</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Obstructive Pulmonary Emphysema</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (i) (this hospital) attended the deceased from <i>1/4/69</i> , to <i>1/4/69</i> , that (i) (we) last saw the deceased alive on <i>1/4/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert C Macon</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/4/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert C Macon</i>					22e. ADDRESS <i>809 Viers Mill Rd, Rockville</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/7/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>					25a. REC'D BY REGISTRAR <i>JAN 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>G. Williams Judge</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18-22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-7-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Nancy			Middle Lou			Last Brown			2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1 16 19 69			2b HOUR M		
3 SEX female		4 RACE White		5 DATE OF BIRTH 1/26/37		6 AGE (In years last birthday) 31 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Jan Day 16 Year 1969			2d HOUR 11:35		
7a BIRTHPLACE (State or foreign country) Ill.				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery				A.M. M.D.	
10 CITY OR TOWN OF DEATH Silver Spring, Md				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hswf.				12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b COUNTY Mont.		13c CITY OR TOWN Silver Sp.		13d INSIDE CITY, M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 12813 Hathaway Dr.							
14 FATHER'S NAME First Middle Last Deceased						15. MOTHER'S MAIDEN NAME First Middle Last Zola M. Payne											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO (If yes give year or dates of service) 227 46 8610				17 INFORMANT ADDRESS husb/Andrew S 12813 Hathaway Dr Wheaton Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART 1. DEATH WAS CAUSED BY.																	
IMMEDIATE CAUSE (a) Cardiorespiratory failure due to																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) Barbiturate intoxication																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. 10 P.M. 1-16 19 69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased, depressed, took overdose of barbiturate (Fuinol)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f LOCATION Street or R.F.D. No City or Town Silver Spring				County Montgom. Md.					
22a. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				Belden R. Keap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>					
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED JAN. 16, 1969					
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial				Jan. 18, 1969		National Mem. Park				Falls Church Virginia							
24 FUNERAL DIRECTOR Tyson Wheeler F.H. 1331 Rockville Pike Rockville, Md.								25a REC'D BY REGISTRAR JAN 21 1969				25b REGISTRAR'S SIGNATURE Alvin Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Deceased to Dr. x Golden Keap

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
DECEASED-NAME (Type or print) First Middle Last ROSIE ANNA BROWN					2a. DATE OF DEATH Month Day Year 1- 15- 69			2b. HOUR 3:30 PM		
3 SEX FEMALE		4 RACE NEGRO		5 DATE OF BIRTH AUG 22, 1878			6. AGE (In years lost birthday) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SYLVAN MANOR CARE CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) UNEMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admn sion) STATE MD		13b. COUNTY MONTG.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2700 BARKER STREET		
14. FATHER'S NAME First Middle Last HENSON DOW		5. MOTHER'S MAIDEN NAME First Middle Last LUCINDA ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 218-54-9118		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART . DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fiber</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>Dec 19 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.										
22b. SIGNATURE <i>Robert Thibadeau</i> DECEASED					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-17-69</i>			
22d. PHYSICIAN'S NAME (Type) R. THIBADEAU					22e. ADDRESS ROCKVILLE, MD 20852					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 1-18-69		23c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL		23d. LOCATION (City or Town) (County) (State) SANDY SPRING, MONTG, MD				
24. FUNERAL DIRECTOR ROBERT L. SNOWDEN					ADDRESS ROCKVILLE, MD		25a. REGD. BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE <i>John Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR 45M 169

01011												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												J1012											
Item #6, Film 09 1/30/69 km												CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or print) SALLIE						First M Middle BROWN Last						2a. DATE OF DEATH Month 1 Day 21 Year 69						2b. HOUR 4 MIN 12																	
3. SEX Female						4. RACE White						5. DATE OF BIRTH 2-24-1885						6. AGE (In years last birthday) 83 YRS						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 											
7a. BIRTHPLACE (State or foreign country) Md.						7b. CITIZEN OF WHAT COUNTRY USA						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH Montgomery						Md.											
10. CITY OR TOWN OF DEATH Bethesda						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shubert						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.						13b. COUNTY Mont.						13c. CITY OR TOWN Rockville						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER 5763 Halpine Road											
14. FATHER'S NAME First Andrew Middle Clinton Last Brown						15. MOTHER'S MAIDEN NAME First UNKNOWN Middle Last 						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)						16b. SOCIAL SECURITY NO None						17. INFORMANT Edith C. Sharent Address 5763 Halpine Rd. Rockville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. Years 																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized Arteriosclerosis and Exogenous obesity																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. 19 Month 1 Day 21 Year 69 P.M. 						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State 																							
22a. I certify that (I) (the hospital) attended the deceased from 18 Jan. 1969 , to 21 Jan. 1969 , that (I) (we) lost saw the deceased alive on 21 Jan. 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Horace W. Berenton												DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 21 Jan 69																	
22d. PHYSICIAN'S NAME (Type) HORACE W. BERENTON, M.D.												22e. ADDRESS 4743 Bradley Blvd. Ch. Ch. Md																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE 1-24-69						23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery						23d. LOCATION (City or Town) (County) (State) Beallsville, Mont. Md.																	
24. FUNERAL DIRECTOR Robert A. Pumphrey												ADDRESS 7557 Wisconsin Ave						25a. REC'D BY REGISTRAR 27 JAN 1969						25b. REGISTRAR'S SIGNATURE Charles Judge											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15/12
30M REV 1-60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Ethel Eudora Brownie						Jan 6 1969				
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female		white		12-25-19		49 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Wash. D.C.		America U.S.				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Wash. San & Hosp.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Md.			PRINCE GEORGE ADELPHI			YES			2317 UNIVERSITY BLVD. E.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Ferdinand			Bergmann			Anne E. White				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address	
No			213-14-8723			EDWIN L. BROWNIE			SAME AS #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis of heart with metastases</u> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1-5</u> , 1967, to <u>1-6</u> , 1969, that (I) (we) last saw the deceased alive on <u>1-5</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Sernach T. Kimble M.D.</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-6-69.		
22d. PHYSICIAN'S NAME (Type) Sernach Kimble, M.D.				22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		JAN 9, 1969		FT. LINCOLN CEM		COLMAR MANOR, MARYLAND				
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u>				25a. REC'D BY REGISTRAR JAN 14 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 156-10
30M REV 1-68

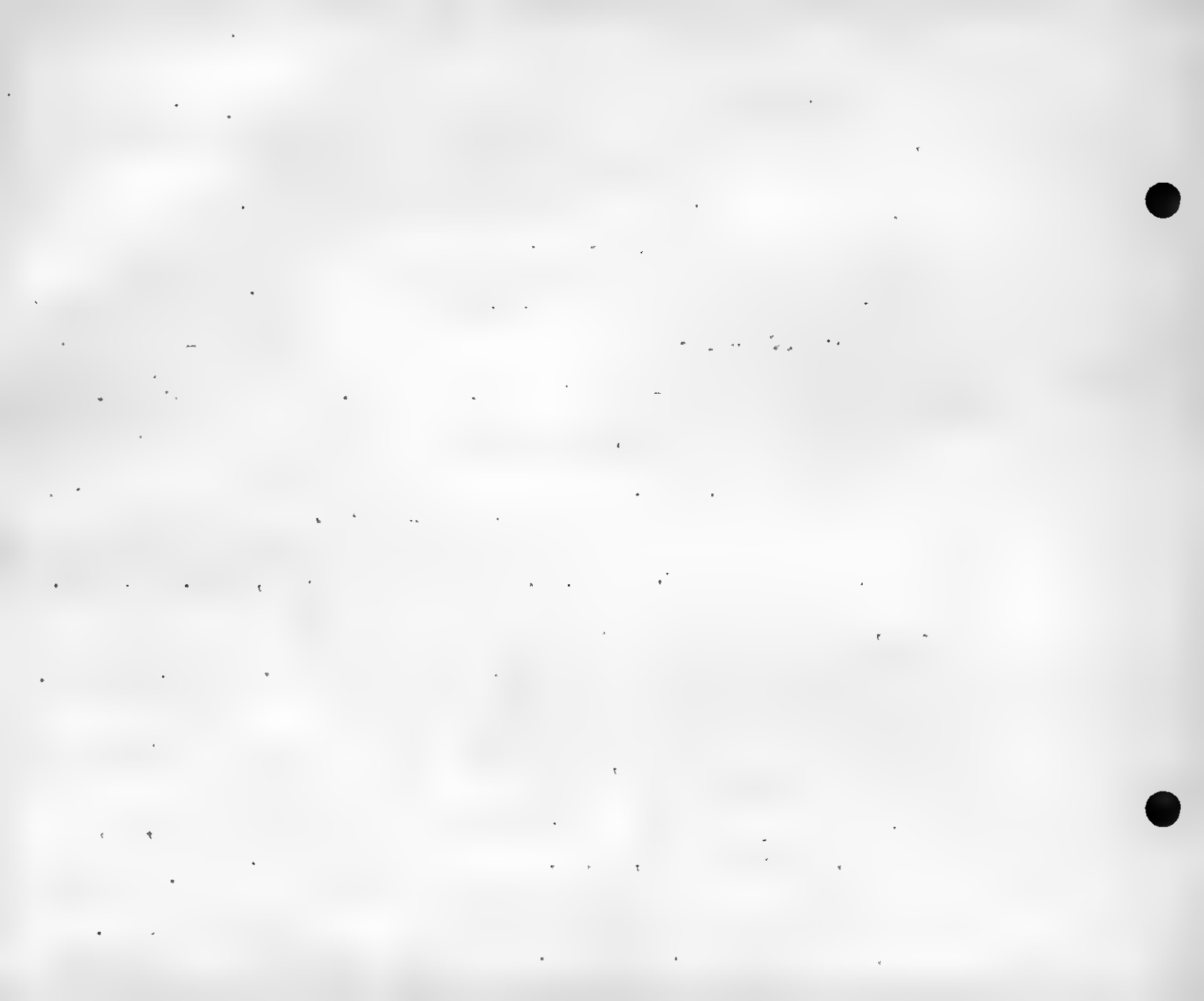
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01019

11014

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Harvey W. Burdette			2a. DATE OF DEATH Month Jan. Day 13 Year 1969			2b. HOUR 9:48	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 22, 1887		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home Potomac Valley Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Woodfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R'D # 1, Gaithersburg		14. FATHER'S NAME First Richard Middle - Last Burdette		15. MOTHER'S MAIDEN NAME First Laura Middle - Last Watkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-46-4915		17. INFORMANT Address R'D # 1, Gaithersburg, Md. Mrs Millie M. Burdette, Gaithersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio-vascular Disease with DUE TO, OR AS A CONSEQUENCE OF Moderate Hypertension. (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 15 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Adeno-carcinoma of the Prostate. (Confirmed by Biopsy, Mont. Gen. Hosp.)							
19a. DATE OF OPERATION Jan. 21, 1966		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypertrophy of Prostate		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No accident contributing to cause of death.			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from about , 19 35 , to January 13, 1969 , that (I) (we) saw the deceased alive on January 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE M. McKendree Boyer, M.D.				22c. DATE SIGNED Jan. 13, 1969		22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.	
22e. ADDRESS 9701 Church Street Damascus, Maryland.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Wesley Grove	
23d. LOCATION (City or Town) (County) (State) Woodfield, Md.		24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 1969		25b. REGISTRAR'S SIGNATURE William Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR-10 (4)
30M RE-1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1015

1 DECEASED-NAME (Type or print) Anna J. Burgraff			2a. DATE OF DEATH Jan 10, 1969 Year			2b. HOUR 9:00				
3. SEX Female		4 RACE White		5 DATE OF BIRTH July 28, 1886		6 AGE (In years last birthday) 82 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) S. Dakota		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Rockville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 199 Rollins Ave.			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY	
13a. USJAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 199 Rollins Ave.	
14. FATHER'S NAME First Middle Last John Sechser			15. MOTHER'S MAIDEN NAME First Middle Last Antonette Portz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) NO (If yes give year or dates of service) NO			16b. SOCIAL SECURITY NO. 579 26 9561B		17. INFORMANT g Address Richard Burgraff (Same As Above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 41-7 DUE TO, OR AS A CONSEQUENCE OF ASAD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 5 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) diabetes mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/29, 1965 to 12/18, 1968 , that (I) (we) lost saw the deceased alive on 12/18/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Myron L. Lenkin DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1/10/69				
22d. PHYSICIAN'S NAME (Type) Myron L. Lenkin, M.D.						22e. ADDRESS 2309 S. orefield Road, Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial			23b. DATE 1/13/1969		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Washington D.C.		
24. FUNERAL DIRECTOR Tyson Wheeler R.H. ADDRESS 1331 Rockville Pike Rockville, Maryland						25a. REC'D BY REGISTRAR DATE JAN 14 1969		25b. REGISTRAR'S SIGNATURE John J. Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and retained with 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
01021		CERTIFICATE OF DEATH						01016					
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
ADA FRANCES			BURTON		SAN		Month 18 Day		Year 69		7:5A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		WHITE		AUG 5, 1896			82 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
MARYLAND		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY Co.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
BERMANTOWN			THE MARYLANDER HOUSE			HOUSE WIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
MARYLAND			MONTGOMERY		BETHESDA		YES		RTH 1 BOX 14				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
EZRA COPPERSMITH			BARBARA WILLIAMS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address					
			215-18-3816		MRS MARGARET WESTFALL			BOX 14 MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident										2 days			
4122 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a):													
(b) Hypertensive cardiovascular disease										years			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Right hemiplegia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 11, 1966 to Jan 18, 1969, that (I) (we) last saw the deceased alive on Jan 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
JOHN G. JANCETI M.D.													
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		1/21/69		David Ridge Cemetery		Pikesville		Baltimore		Md			
24. FUNERAL DIRECTOR					ADDRESS		25a. JAN 22 1969		25b. REGISTRAR'S SIGNATURE				
R.S. Jancetti, Jr., Baltimore, Md.							DATE		J. Charles Judge				

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>01020</div> <div>01017</div> <div>CERTIFICATE OF DEATH</div>										
1. DECEASED-NAME (Type or print) First Middle Last Gussie(Grace) Butt					2a. DATE OF DEATH Month Day Year Jan 7 69			2b. HOUR 6A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 14-1894		6. AGE (In years last birthday) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md				
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESLADY		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11522 TABER STREET	
14. FATHER'S NAME First Middle Last MOSES			15. MOTHER'S MAIDEN NAME First Middle Last RASNER FLORENCE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER MRS. FLORENCE DELKER. Address 11522 TABER ST. SILVER SPRING, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of rectum with metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH X-YR	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>69</u> , to <u>Jan 7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Myron L. Lenkin MD DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/7/69			
22d. PHYSICIAN'S NAME (Type) MYRON L. LENKIN MD					22e. ADDRESS 2309-Shorefield Rd. Wheaton Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-9-69		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON CEMETERY		23d. LOCATION (City or Town) (County) (State) BROOKLYN N.Y.				
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASHINGTON DC					25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-1-68
3044 REV.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1018			
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		2b HOUR		
GREY			G.		BYRD				JAN 14, 1969		M		
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		NEGRO		11-14-1896				72 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH					
		U.S.A.		WIDOWED		DIVORCED		MONTGOMERY					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
KENSINGTON			3500 Mertford Street				HOUSEWIFE			NONE			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
MD			MONTG.		KENSINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3900 MERTFORD ST.				
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First	
JOHN							FFORTUNE		CHRISTINE			FORTUNE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT				Address				
No					MRS CHARLOTTE BAILEY								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>1000</u> <u>Hysteria</u>										3 days			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>adenocarcinoma ovaries</u>										6 mo			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic cancer</u>										6 mo			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. Month Day Year										
(If either, notify medical examiner)			P.M. 19										
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION		Street or R.F.D. No.		City or Town		County	
While <input type="checkbox"/> Not while <input type="checkbox"/>													
at work <input type="checkbox"/> at work <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>68</u> , to <u>1-14-69</u> , that (I) (we) last saw the deceased alive on <u>1-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
<u>John C Robben MD</u>										<u>1-14-68</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
<u>John C Robben MD</u>						<u>10400 Connecticut Ave Kensington</u>							
23a BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
<u>BURIAL</u>			<u>1-19-69</u>		<u>ASH MEMORIAL Cem.</u>		<u>Spring Spring Md.</u>				<u>Md.</u>		
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Robert L. Snowden</u>						<u>Rockville Md.</u>		<u>JAN 20 1969</u>		<u>James Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			2b HOUR
Earl Benjamin Calhoun						ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			6 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 24 HRS MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD	2d HOUR
Male	White	12/16/12	56 YRS					Jan 12	7 AM
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Virginia	USA			Montgomery					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban			Farmer			Farming		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER					
MD	Montgomery	Bethesda		1425 Trandell Rd					
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Benjamin F.		Calhoun		Mary			Maguire		Parker
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
			212-16-5096			Wife - Eva Calhoun Jones			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Left Lung w/ Metastasis</u>								8 Month	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
		19 P.M.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
John G. Ball			John G. Ball					Jan 12, 1969	
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			1-15-69		Laytonville		Laytonville Mont. Md.		
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Francis H. Barber Laytonville, Md.				JAN 16 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
01020												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) WILLIAM G Campbell						2a. DATE OF DEATH Month JAN Day 10 Year 1969			2b. HOUR 5:00 A.M.			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 4-16-1899		6. AGE (In years last birthday) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY						
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER				
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		3d. INSIDE CITY, M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER PARK Avenue		
4. FATHER'S NAME First CHARLES Middle Last Campbell				15. MOTHER'S M.A.DEN NAME First Unknown Middle Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 		17. INFORMANT George Campbell - son - Address SAME						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cor pulmonale 472X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary emphysema and bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State 				
22a. I certify that (I) (this hospital) attended the deceased from 1/1 , 19 69 , to 1/10 , 19 69 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE E. J. Levin				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) EDGAR LEVIN				22e. ADDRESS								
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE 1-13-1969		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.				23d. LOCATION (City or Town) (County) (State) Rockville, Maryland				
24. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.				25. DIED BY REG. STAMP JAN 10 1969		25a. REGISTRAR'S SIGNATURE 		

1



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01020			01021		
1. DECEASED NAME (Type or print) James Thomas Cantrell			2a. DATE OF DEATH Month January Day 1 Year 1969		
3 SEX Male		4. RACE White		5. DATE OF BIRTH 15 March 1916	
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) 52 YRS.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		9. COUNTY OF DEATH Montgomery Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE South Carolina COUNTY Spartanburg		13c. CITY OR TOWN Spartanburg		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Leander Middle Cantrell Last Cantrell		15. MOTHER'S MAIDEN NAME First Mary Middle Emma Last Page			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 247-28-4974		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive aspiration of vomitus 2001 DUE TO, OR AS A CONSEQUENCE OF (b) Pan-lobar pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Lymphosarcoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 Minutes 2 Weeks 6 Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 16 Dec. , 19 68 , to 1 Jan. , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 January , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE C. H. Brown, III, M.D.		DEGREE MD		22c. DATE SIGNED 2 January 1969	
22d. PHYSICIAN'S NAME (Type) C. H. Brown, III, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/3/69		23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens, Chesnee, S. Carolina	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REG. BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) MARY First CATHERINE Middle CARMODY Last			2a. DATE OF DEATH Month January Day 12 Year 1969				2b. HOUR 7:25 M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH December 9, 1930		6 AGE in years last birthday 38 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Wash. D.C.		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Kensington		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gds			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Wash. D.C.			13b COUNTY Montgomery		13c CITY OR TOWN Wash. D.C.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1406 Allison St. N.W.	
14 FATHER'S NAME John First McGraith Middle Mary Carmody Last			15 MOTHER'S MAIDEN NAME Mary Carmody First McGraith Middle Mary Carmody Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give year or dates of service)			16b SOCIAL SECURITY NO 577-62-1457		17 INFORMANT Chart.		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4101 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 3 1/2 hours										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral Thrombosis										
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year None P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) None						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from September 30, 1968, to January 14, 1969 , that (I) (we) last saw the deceased alive on January 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James M. Loftus				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED January 14, 1969		
22d. PHYSICIAN'S NAME (Type) James M. Loftus				22e. ADDRESS 5415 Conn. Ave. N.W.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/17/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City or Town) (County) (State) Ft. Myer, Va.			
24. FUNERAL DIRECTOR The S.H. Hines Company				ADDRESS 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

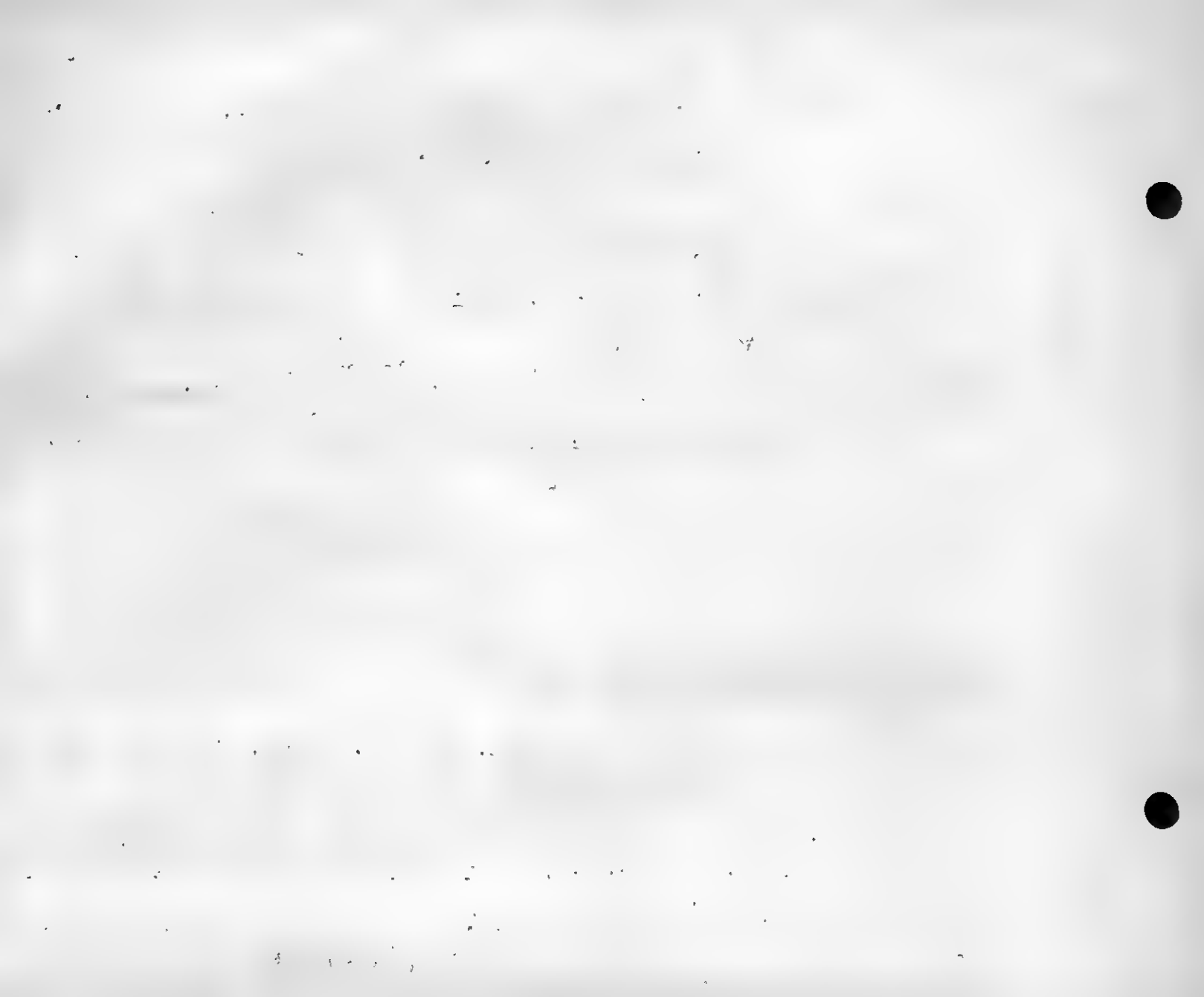
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS
30M RE-148

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M		
Kent			Andrew		Carpenter	January 10, 1969			5:30		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		16 November 1959		9 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Montgomery			Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		The Clinical Center, NIH		Student		grade school					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Prince Georges		Adelphi				1900 Ruatan Street			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George			W.		Carpenter	Bettie			--		Gifford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address					
No				None		The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>lymphoblastic leukemic transformation</u>										8 Months	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from Dec. 31, 1968, to Jan. 10, 1969, that (X) (we) last saw the deceased alive on January 10, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death											
22b. SIGNATURE				22c. DATE SIGNED							
Sherrard L. Hayes, M. D.				10 January 1969							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
The Clinical Center, National				Institutes of Health, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
1-13-1969		George Washington Co.		Hunttsville Pr. Geo. Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John Carter		8434 Georgia Avenue		DATE JAN 16 1969							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Agatina Cerra						2a. DATE OF DEATH Month Day Year Jan 30 69			2b. HOUR 6 A. M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 21 AUGUST 1888			6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH SILVER SPRING MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 14813 Harold Rd.,				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HW			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2405 Hermitage Ave.,				
14. FATHER'S NAME First Middle Last SALVATORE GUIFFREDA						15. MOTHER'S MAIDEN NAME First Middle Last MARIA LIPARI						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-52-5249		17. INFORMANT JOHN B. CERRA				Address 13a, b, c, d and e ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CVA												
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis												
DUE TO, OR AS A CONSEQUENCE OF (c) Ca Colon												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) General Wasting												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 30 1969 , to Jan 30 1969 , that (I) (we) last saw the deceased alive on Jan 30 1969 , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE R. S. Bufalino						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan 30, 69				
22d. PHYSICIAN'S NAME (Type) Russell BUFALINO						22e. ADDRESS 1429 Univ. Blvd W, Silver Spring, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3 FEBRUARY 1969		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET				23d. LOCATION (City or Town) (County) (State) WASHINGTON DC.				
24. FUNERAL DIRECTOR LINDA J. FUNERAL HOME						25a. REC'D BY REGISTRAR FFR		25b. REGISTRAR'S SIGNATURE John B. Cerra				
7400 GEORGIA AVE., N.W., DC 20012						DATE 9 10 68						

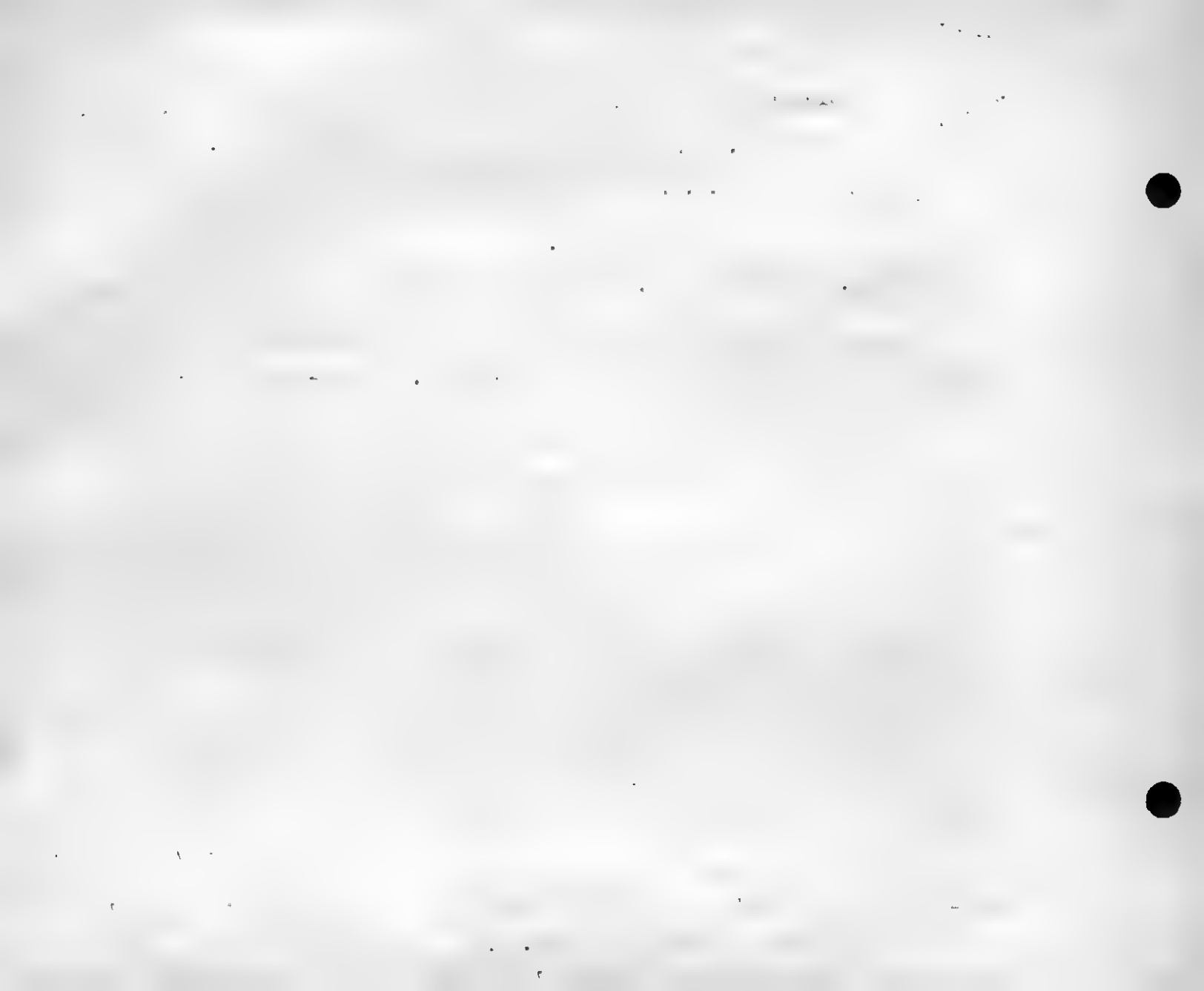
FOR STATE HEALTH DEPT.

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MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR	
Elnora		J.		Clark				M		Jan.		23		19		69	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year	
female	White	Nov. 22, 1935		35		MONTHS		DAYS		Hours		Min		Jan.		25	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Kentucky		U.S.A.		WIDOWED		DIVORCED		Montgomery									
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Rockville		542 Beall Ave.,		Housewife													
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md.		Mont.		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		542 Beall Avenue									
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
Robert Stanley Wallingford								Lora Mitchell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
No				Robert P. Clark - husband - same item #13													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple severe head and brain 766X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) lacerations inflicted with a DUE TO, OR AS A CONSEQUENCE OF sharp instrument (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year 3 00 P.M. 1-24 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased attacked by son who struck her with hatchet.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State 542 Beall Ave. Rockville Mont. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Belden A. Acap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED JAN. 25, 1969					
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City or Town) (County) (State) Maysville, Mason, Kentucky									
23a. B. RIAL CREMATION <input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> (Specify)				23b. DATE 1/31/69				23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Maysville, Mason, Kentucky					
24. FUNERAL DIRECTOR Tyson Wheeler				ADDRESS Funeral Home 1331 Rock Pike Rockville, Maryland				25a. REC'D BY REGISTRAR JAN 30 1969				25b. REGISTRAR'S SIGNATURE					



FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

First Robert		Middle Franklin		Last Clark		2a. DATE KNOWN OF DEATH Month Jan. Day 23 Year 1969		2b. HOUR M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH Jan 7, 1961	6 AGE (in years last birthday) 8 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Jan. Day 25 Year 1969		2d. HOUR 11:44	
7a. BIRTHPLACE (State or foreign country) North Carolina Usa		7b. CITIZEN OF WHAT COUNTRY? Usa		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 542 Beall Ave.,		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 542-Beall Avenue	
14 FATHER'S NAME First Robert P. Middle Clark Last Clark			15. MOTHER'S MAIDEN NAME First Elnora Middle Wallingford Last Wallingford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Robert P. Clark-father-same item # 13		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 963X IMMEDIATE CAUSE (a) Asphyxiation due to strangulation DUE TO, OR AS A CONSEQUENCE OF with neckerchief Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year (HOUR A.M. OR P.M.) 3:00 AM 1-24 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Deceased assaulted by older brother who strangled him.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. 342 Beall Ave.		City or Town Rockville		County Montg	State Md.
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURLIAL CREMATION Burial-transit		23b. DATE 1/31/69		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City or Town) Maysville, Mason,		State Kentucky	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rockville		25a. REC'D BY REGISTRAR PARK 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]	
Rockville, Md.									



FOR STATE HEALTH DEPT.

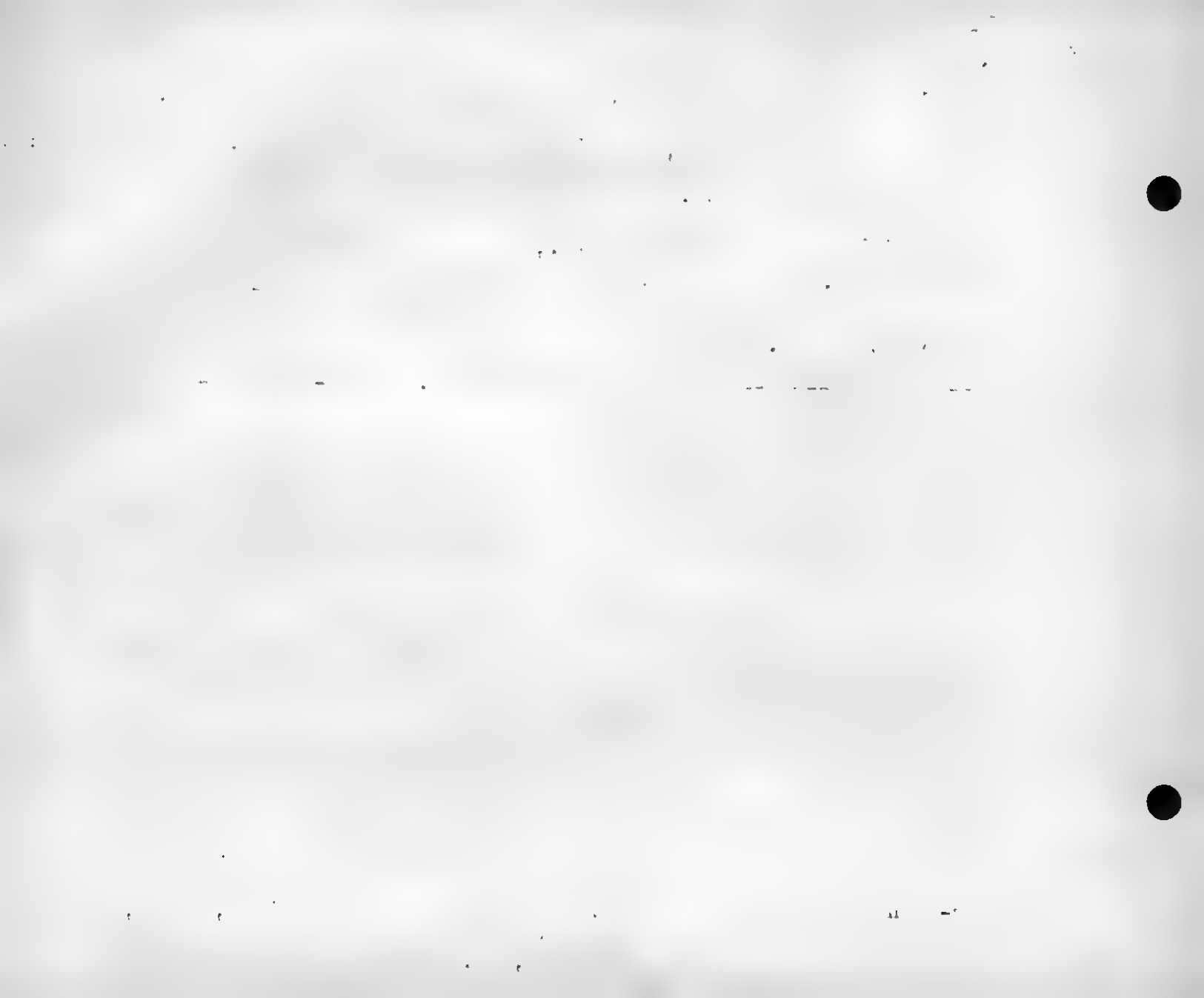
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		ESTIMATED	Month	Day	Year	2b HOUR
Roberta		C.		Clark	Jan. 24			19	69		M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
Female	White	March 17, 1955		15 YRS	MONTHS DAYS		HOURS MIN.		Month Jan. Day 25 Year 19 69		11:40 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Kentucky		U.S.A.		WIDOWED		DIVORCED		Montgomery		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Rockville		542 Beall Ave.,				Student					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md.		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		542-Beall Avenue			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last		
Robert			P.	Clark	Elnora				Wallingford		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Robert P. Clark - father - same item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple severe head and brain											
DUE TO, OR AS A CONSEQUENCE OF (b) lacerations inflicted with a sharp											
DUE TO, OR AS A CONSEQUENCE OF (c) instrument											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
				3:00 P.M. 1-24 19 69				Deceased assaulted with hatchet by brother.			
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Home				542 Beall Ave. Rockville Montg. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER		JAN. 25, 1969			
						ADDRESS (City or Town or County)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial-transit		1/31/69		Olivet Cemetery		Mayesville, Mason, Kentucky					
24 FUNERAL DIRECTOR		Tyson Wheeler		Funeral Home		1331 Rockville Pike Rockville, Md.		RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
								JAN 30 1969		John A. Gudge	

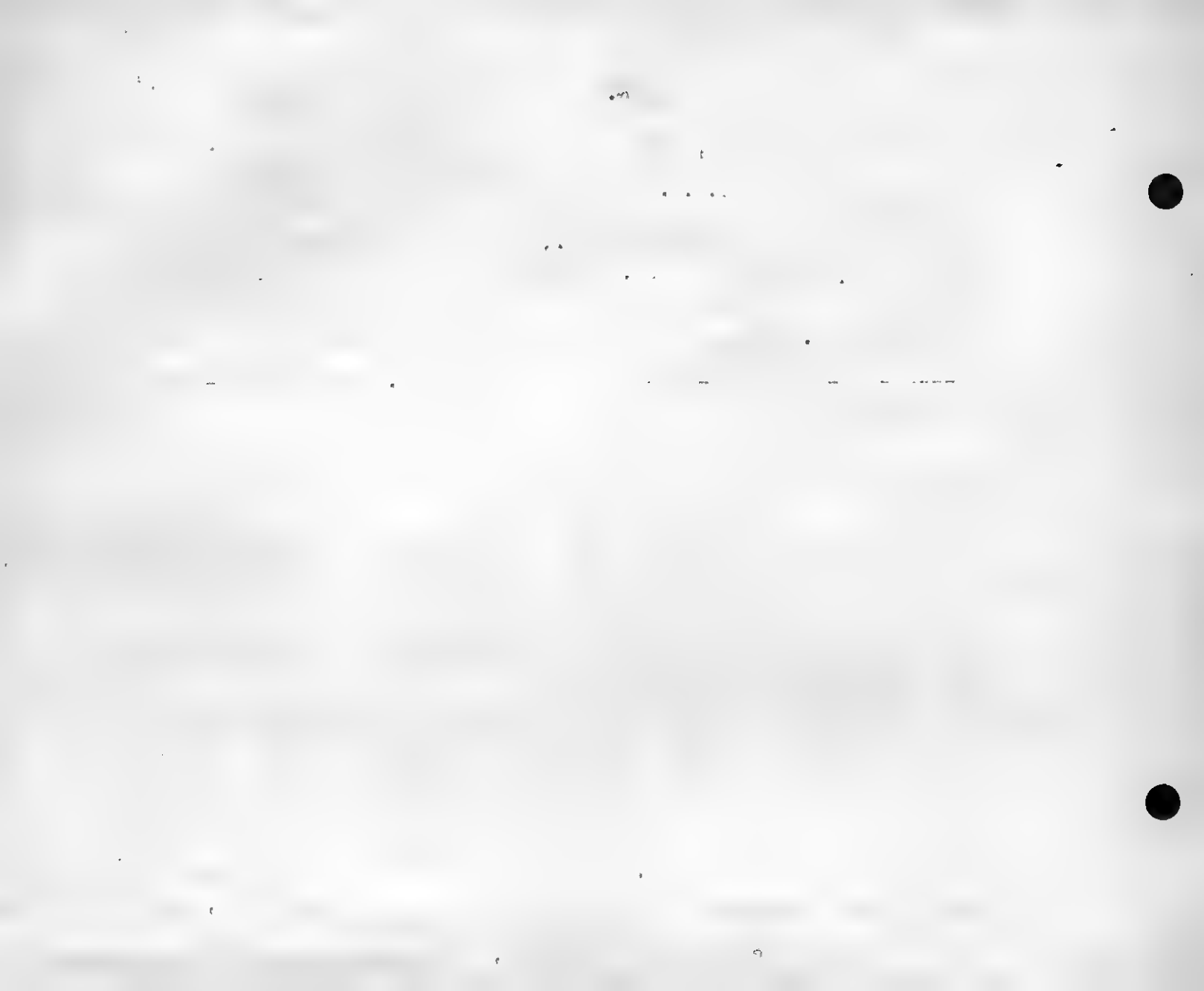


FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										51028	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
Susan			R.		Clark				Jan. 24 1969		M
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR
Female	White	Feb 28, 1958		10 YRS					Jan. 25 1969		11:4
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Virginia		U.S.A.				Montgomery Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Rockville			542 Beall Ave.,			Student					
13a USUAL RESIDENCE (Where deceased lived, if first location address an) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Mont.		Rockville				542-Beall Avenue		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
First Middle Last					First Middle Last						
Robert P. Clark					Elnora Wallingford						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
				-----		Robert P. Clark-father-same item #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple severe head and brain											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) lacerations inflicted with a sharp											
DUE TO, OR AS A CONSEQUENCE OF instrument											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH		3:00 PM 1-24 1969		Deceased assaulted with hatchet by brother.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
		Home		542 Beall Ave.		Rockville		Montg.		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
Belden R. Keap		Belden R. Keap M.D.						JAN. 25, 1969			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Bur-transit		1/31/69		Olivet Cemetery		Maysville, Mason,		Kentucky			
24 FUNERAL DIRECTOR				25a DECEASED BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home				Rockville, Maryland				JAN 30 1969			



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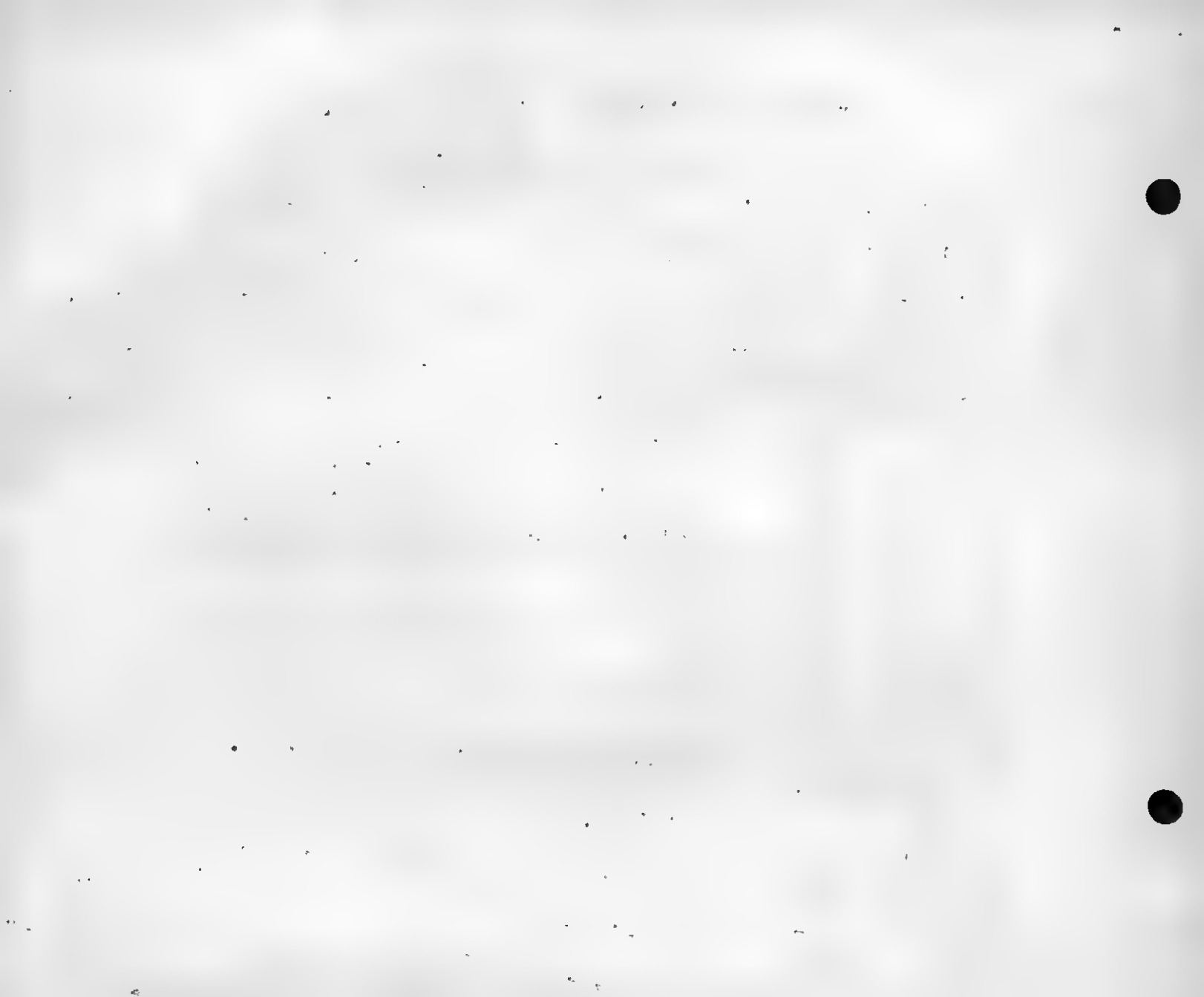
01029

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Suzanne Patricia Coldren			2a. DATE OF DEATH Month Day Year January 20 1969			2b. HOUR 8:55 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 22 May 1951		6. AGE (in years last birthday) 17 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13b. COUNTY Shillington		13c. CITY OR TOWN Shillington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 423 North Brobst Street		14. FATHER'S NAME First Middle Last Richard L. Coldren		15. MOTHER'S MAIDEN NAME First Middle Last Nitzi Yerger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO Not Available		17 INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia due to pseudomonas DUE TO, OR AS A CONSEQUENCE OF gastric and duodenal ulcers (b) Massive gastrointestinal hemorrhage from / DUE TO, OR AS A CONSEQUENCE OF lungs, liver, peritoneum (c) Carcinoma of the left adrenal metastatic to / Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 1 week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that the (this hospital) attended the deceased from 26 Dec. , 19 68 , to 20 Jan. , 19 69 , that it (we) last saw the deceased alive on 20 January , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above the (we) (did) not view the body after death							
22b. SIGNATURE <i>Peter J. Deckers</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED January 21, 1969	
22d. PHYSICIAN'S NAME (Type) Peter J. Deckers, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-22-69		23c. NAME OF CEMETERY OR CREMATORY Forrest Hills		23d. LOCATION (City or Town) (County) (State) Exeter Township Berks, Pa	
24. FUNERAL DIRECTOR Robert A. Pumphrey				7557 Wisconsin Ave Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JAN 24 1969	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M 1969

01030		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01030	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print) First Middle Last Edith E. Collins			2a DATE OF DEATH Month Day Year Jan 22, 1969			2b HOUR 8:30 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 10/6/90		6 AGE (In years last birthday) 78 YRS	
7a. BIRTHPLACE (State or foreign country) London Eng.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) at home		12b KIND OF BUSINESS OR INDUSTRY	
13a USUA. RES. DENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Mont.		13c CITY OR TOWN Green Acres		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 5018 - Malden Dr.		14 FATHER'S NAME First Middle Last -		15 MOTHER'S MAIDEN NAME First Middle Last -			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) -		16b SOCIAL SECURITY NO -		17 INFORMANT Alex Young, Friend, Toronto, Canada		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4127 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis with DUE TO, OR AS A CONSEQUENCE OF (c) Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1 Jan, 1964, to 22 JAN 19 69, that (I) (we) last saw the deceased alive on 22 JAN 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. H. Richwine M.D.		22c. ADDRESS 5222 WESTERN AVE. CHEVY CHASE, M.D.		22d. DATE SIGNED 1969			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE 1-24-1969		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or town) (County) SUITLAND, PRINCE GEORGES Co., MD.	
24 FUNERAL DIRECTOR Joe Lamber Sans		ADDRESS 5730 Wisc Ave. NW.		25a REC'D BY REGISTRAR DATE JAN 29 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01031

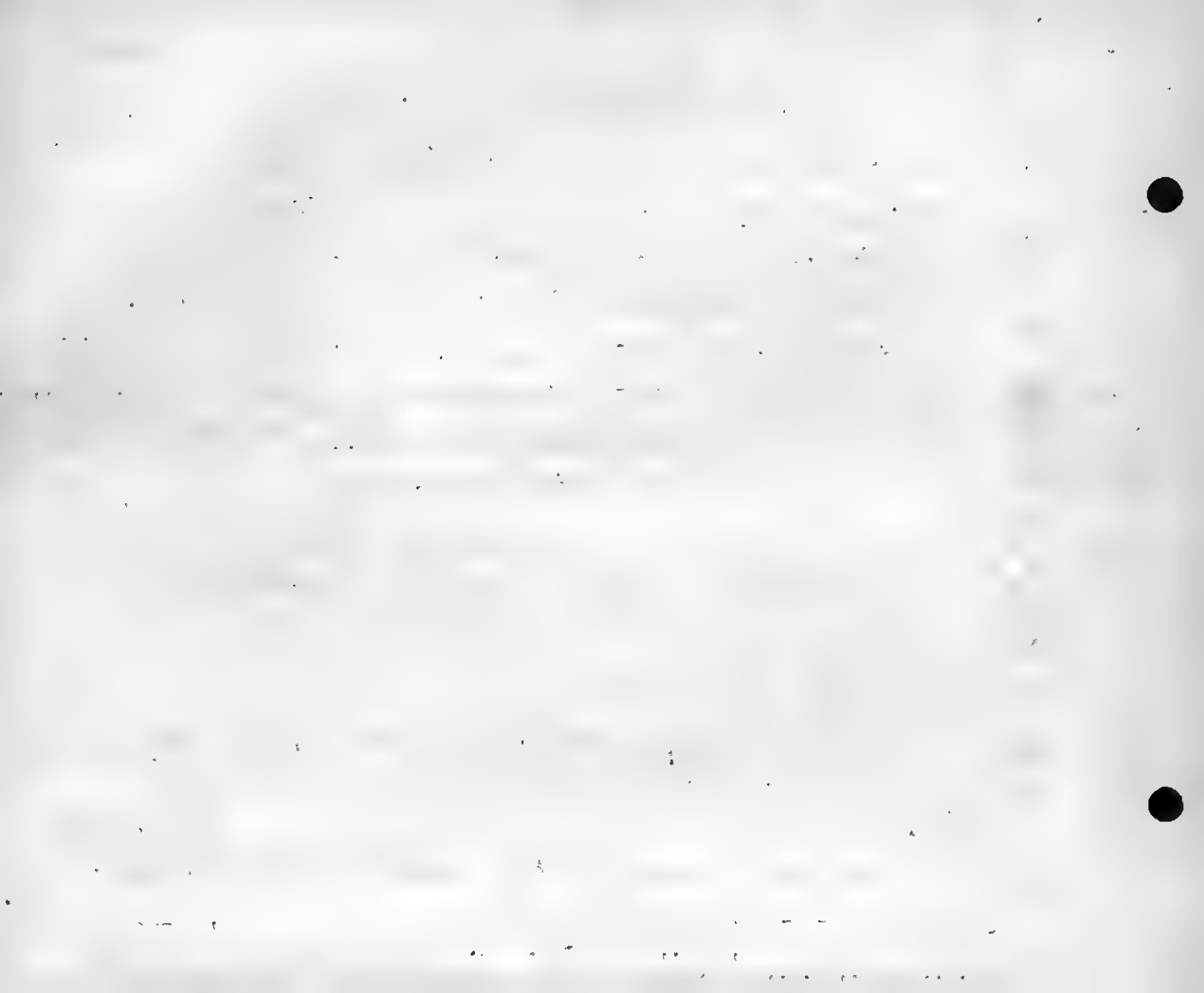
1. DECEASED-NAME (Type or print) Irene O. Collins			2a. DATE OF DEATH Month 7 Day 22 Year 69			2b. HOUR 5:30 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-30-1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH Mont. Co. Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Wheaton Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House W. f. c.			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN GARRETT PK.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11123 Kokeby Ave	
14. FATHER'S NAME John W. Lynch			15. MOTHER'S MAIDEN NAME Deceased - L. Roberts L. Connolly			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No					
16b. SOCIAL SECURITY NO. 578-05264			17. INFORMANT Mr. Robert L. Millard						Address Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 412.3 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 6 yrs. 6 yrs.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1958 , 19 June , 19 June , that (II) (we) last saw the deceased alive on 20 Jan 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) did (did not) view the body after death											
22b. SIGNATURE Charles E. Kegan Jr.			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 22 Jan 69		
22d. PHYSICIAN'S NAME (Type) CHARLES KEGAN JR.			22e. ADDRESS 3752 Benton St NW Wash. DC 20007								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 25, 69			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cen			23d. LOCATION (City or Town) (County) (State) Wheaton, Mont. Co., Md.		
24. FUNERAL DIRECTOR H. D. DeVol			ADDRESS 2222 Wisconsin N.W.			25a. REC'D BY REGISTRAR 24 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Filed by Dr. Edw. Witowski

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
JAMES			STANLEY	CONRAD	Jr.	January 9 1969			7:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		7/16/06		62 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hospital			Plasterer		Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Wheaton			12302 Dalewood Dr.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
James			Stanley	Conrad		Elizabeth			Hummer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			175-05-0393		Frances I. Conrad Address 12302 Dalewood Dr. Whtn., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intracerebral Hemorrhage Right Hemisphere</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cor Pulmonale due to Pulmonary Emphysema</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. YES, WE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>12/30</i> , 19 <i>57</i> , to <i>1/9</i> , 1969, that (I) (we) lost the deceased alive on <i>1/9/69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Edward S. Witowski, Jr. M.D.</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Jan 10, 1969</i>		
22d. PHYSICIAN'S NAME (Type) <i>EDWARD S. WITOWSKI, JR. M.D.</i>					22e. ADDRESS <i>8218 WISCONSIN AVENUE BETHESDA MARYLAND 20014</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) Md.		
Burial		1-13-1969		Fort Lincoln Cemetery			Wolmar Manor, Prince Georges Co.		
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>					25. REG'D BY REGISTRAR <i>JAN 10 1969</i> DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		1033					
1. DECEASED-NAME (Type or Print) <i>First</i> <i>Ave Lino</i> <i>Middle</i> <i>Constantino</i> <i>Last</i>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>Jan. 23 1969</i>		2b. HOUR <i>7:15 P.M.</i>							
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>6/4 1908</i>		6 AGE (In years last birthday) <i>66</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.		2c. DATE PRONOUNCED DEAD Month <i>Jan.</i> Day <i>23</i> Year <i>1968</i>		2d. HOUR <i>7:40 P.M.</i>							
7a. BIRTHPLACE (State or foreign country) <i>Cuba</i>				7b. C. TYPE OF WHAT COUNTRY? <i>Cuba</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md									
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Boulevard</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Bank Teller</i>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>				13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY, Y.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8200-Jefferson St.</i>									
14. FATHER'S NAME <i>First</i> <i>Pedro</i> <i>Middle</i> <i>Canstanzo</i> <i>Last</i>										15. MOTHER'S MAIDEN NAME <i>First</i> <i>Esperanza</i> <i>Middle</i> <i>Prieto</i> <i>Last</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO. <i>224-72-0609</i>				17. INFORMANT <i>8200 Address Person Street, Mrs. Felecia C. Constanzo, Bethesda, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> <i>4124</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost } (b) <i>Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i>P.M.</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>John G. Ball</i>				EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>Jan 23 1969</i>							
ADDRESS (Street, city, town, or county) <i>Bethesda, Maryland</i>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>1-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>				23d. LOCATION (City or Town) <i>Falls Church, Virginia</i> (County) (State)									
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>								25a. REC'D BY REGISTRAR <i>Jan 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

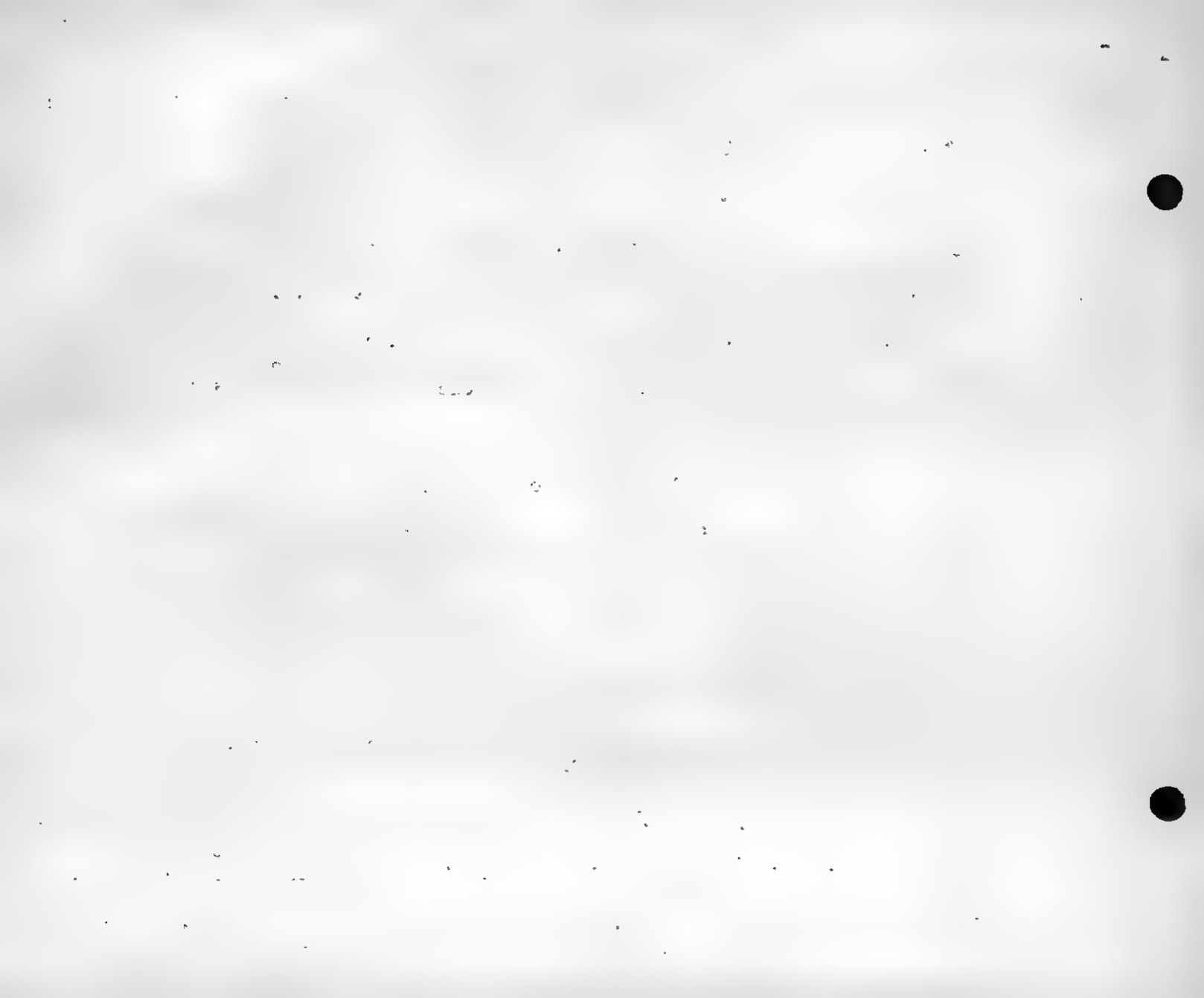
VR 45M 189

1033		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01034	
Item 11 Film 0409 2/5/69 kk		CERTIFICATE OF DEATH			
DECEASED NAME (Type or print) First Middle Last HELEN GRAY COPELAND		2a. DATE OF DEATH Month Day Year JAN 23 1969		2b. HOUR 5: A M	
3 SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH 10-14-1881	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH MONTGOMERY		12a. USUA. OCCUPATION (Kind of work done during life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
10. CITY OR TOWN OF DEATH DICKERSON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Big Woods Road		13a. INSIDE CITY, TOWN, OR VILLAGE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY MONTG.		13c. CITY OR TOWN DICKERSON	
14. FATHER'S NAME First Middle Last WILLIAM COATES		15. MOTHER'S MAIDEN NAME First Middle Last MR WILLIAM COPELAND		16. SOCIAL SECURITY NO NO	
17. INFORMANT MR WILLIAM COPELAND		18. ADDRESS DICKERSON, MD			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>congestive heart failure</u>					
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY _____ HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) _____	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) _____		21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 15, 1968</u> to <u>Jan 23, 1969</u> , that (I) (we) lost the deceased alive on <u>Jan 23, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b. SIGNATURE <u>John J. Lawrence</u>		22c. DATE SIGNED <u>1/23/69</u>	
22d. PHYSICIAN'S NAME (Type) _____		22e. ADDRESS _____			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-27-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	
23d. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		23e. ADDRESS <u>Kockuch, MD</u>		23f. LOCATION (City or Town) (County) (State) <u>Suitland, MD</u>	
24. REC'D BY REGISTERING AGENCY <u>John J. Lawrence</u>		24a. DATE <u>30 1969</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
01040										
01035										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A.M.		
Martin Vincent Coughlin						January 12 1969		1:00 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS		
Male		White		17 September 1951		17 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New Jersey		USA				Montgomery Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			Student				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
New Jersey					Oxford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. #1, Box 333	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Vincent D. Coughlin			Thelma Breiner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		Bethesda, Maryland The Medical Records, The Clinical Center,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia									Days	
2050 DUE TO, OR AS A CONSEQUENCE OF (b) Left Lower Lobe Pneumonia									Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myelogenous Leukemia									1 Year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 12 August, 1968, to 12 Jan., 1969, that (X) (we) last saw the deceased alive on 12 January, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE Robert B. Livingston M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12 January 1969			
22d. PHYSICIAN'S NAME (Type) Robert B. Livingston, M. D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1-15-69		St. Joseph's Cemetery		Washington, New Jersey				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland					JAN 15 1969		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-5-14
30M REV. 1/68

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01041									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
JAMES					CRAIG	Month	Day	Year	5:20 PM
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE			WHITE		12-4-04	67 YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		
IRELAND			U.S.A.		NEVER MARRIED		Montgomery County		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING			Holy Cross Hospital of Silver Spring			Photo Lab Technician		Photo Company	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Montgomery		Silver Spring	YES		2001 MARYMONT ROAD	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First
Samuel					Craig	Marie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			Yes		Julia M. Craig		2001 Marymont Road, S.S., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>11.9</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Emphysema, Atherosclerosis, Heart Disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES		NO	
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. Month Day Year						
(If either, notify medical examiner)			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/>			OFFICE BUILDING, ETC			Street or R.F.D. No City or Town County State			
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/21/68</u> to <u>1/6/69</u> , that (I) (we) last saw the deceased alive on <u>1/6/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
<u>John J. Curry, M.D.</u>			1/6/69			John J. Curry, M.D.			
22e. ADDRESS			22f. ADDRESS			22g. ADDRESS			
9801 Graceland Silver Spring									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			1-10-1969		Parkland Cemetery		Rockville Montgomery Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
M. Andrew Duwall			DATE			JAN 10 1969			
Warner E. Pumphrey, Inc. 8434 Geo. Rd. N.W.						V. C. Jones, Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR A			
Fryling Milton Crawford						January 24 1969		12:40 M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR			
Male		White		December 4, 1907		61 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
District of Col.			United States				Montgomery Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington San. & Hosp.			Adm. Assistant		Fed. Housing			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Prince George		Hyattsville				8124 15th Ave., Apt. #103		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Zedic					Crawford	Ruth					Dawes
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT					
no			217-44-0589			Helen Crawford (Wife) 8124-15th Ave. Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary embolus, acute</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>associated with peripheral emboli.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerotic Heart disease and Congestive Heart Failure.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>17 minutes</u>	
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (the hospital) attended the deceased from 1-12, 1969, to 1-24, 1969, that (I) (we) last saw the deceased alive on 1-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
HARRY N. CARLTON			1/24/69			HARRY N. CARLTON					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial			Jan. 27, 1969		Washington National		Suitland, Maryland				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE				
Warner C. Pumphrey, Inc. 8434-Ga. Ave. Sil. Spg.			JAN 29 1969		Charles Judge						

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1038

1. DECEASED NAME (Type or Print) First Middle Last Pate -- Crawford			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 1 15 1969			2b. HOUR 12:30 P	
3 SEX male	4 RACE white	5. DATE OF BIRTH 6-8-05	6 AGE (In years last birthday) 63 YRS	7 UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 1 15 1969
7a. BIRTHPLACE (State or foreign country) C		7b. CITIZEN OF WHAT COUNTRY? Mex xxx U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Pk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash San & Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Geo		13c. CITY OR TOWN Hyatt		13d. INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2125 Guilford Rd		14. FATHER'S NAME First Middle Last Robert -- Crawford		15. MOTHER'S MAIDEN NAME First Middle Last Ada Freeman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give year or dates of service) 45-20-5569		17. INFORMANT Name and address Crawford 2125 Guilford Rd Hyattsville, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure due to 890X DUE TO, OR AS A CONSEQUENCE OF (b) severe burns (35%) of body and pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 10:30 A.M. 12/22 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased smoking and his shirt caught fire.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Hyattsville Prince Geo. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Kepp		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED JAN. 15, 1969	
EXAMINER'S NAME (Type) BELDEN R. KEPP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, or County) Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-18-1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.	
24. FUNERAL DIRECTOR Enter name and address George A. Ave		ADDRESS S.E. Spr. Md.		25a. REC'D BY REGISTRAR DATE Jan 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Roger			Leo		CREIGHTON, JR.		January		Month 20 Day 69 Year		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			Caucasian			Jan. 20, 1969			YRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Bethesda			USA						Montgomery Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			N/A			N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Montgomery			Wheaton			2413 Homestead Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Roger Lee CREIGHTON SR.			Carol Eileen JORDAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
N/A			N/A			Wheaton			Maryland		
						Roger Leo Creighton, Sr.			2413 Homestead Drive		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atelectasis, bilateral											
DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Jan. 20, 1969, to Jan. 20, 1969, that (X) (we) last saw the deceased alive on Jan. 20, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Gary H. Safley						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			Jan. 21, 1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Gary H. Safley, M.D.						Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1/23/69			Arlington National			Arlington Arlington Va.		
24. FUNERAL DIRECTOR						25a. DATE OF REGISTRATION			25b. REGISTRATION NUMBER		
W. W. Chambers Co.						Jan 30 1969					
1400 Chapin Street, N. W., Washington, D. C.						DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) Louis						2a. DATE OF DEATH Month January Day 11 Year 69			2b. HOUR 2250 P.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Feb. 2, 1900			6. AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virgin Islands		7b. CITIZEN OF WHAT COUNTRY? Unknown		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Janitor			12b. KIND OF BUSINESS OR INDUSTRY Govt.		
13a. USJA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Cuba			13b. COUNTY Guantanamo			13c. CITY OR TOWN Bay		13d. INSIDE CITY L.M. TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Naval Station	
14. FATHER'S NAME First Middle Last Unknown						15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unkn			16b. SOCIAL SECURITY NO 217-52-8246			17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1, (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from Aug. 22 , 19 68 , to Jan. 11 , 19 69 , that (i) (we) last saw the deceased alive on Jan. 11 , 19 69 , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE P. B. Blanchard, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 January 1969			
22d. PHYSICIAN'S NAME (Type) P. B. Blanchard, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL CREMATION OR OTHER DISPOSAL (Specify) Burial		23b. DATE 1-17-69		23c. NAME OF CEMETERY OR CREMATORY U. S. Naval Cemetery				23d. LOCATION (City or Town) (County) (State) Guantanamo Bay Cuba			
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N. W. Washington, D. C.						25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

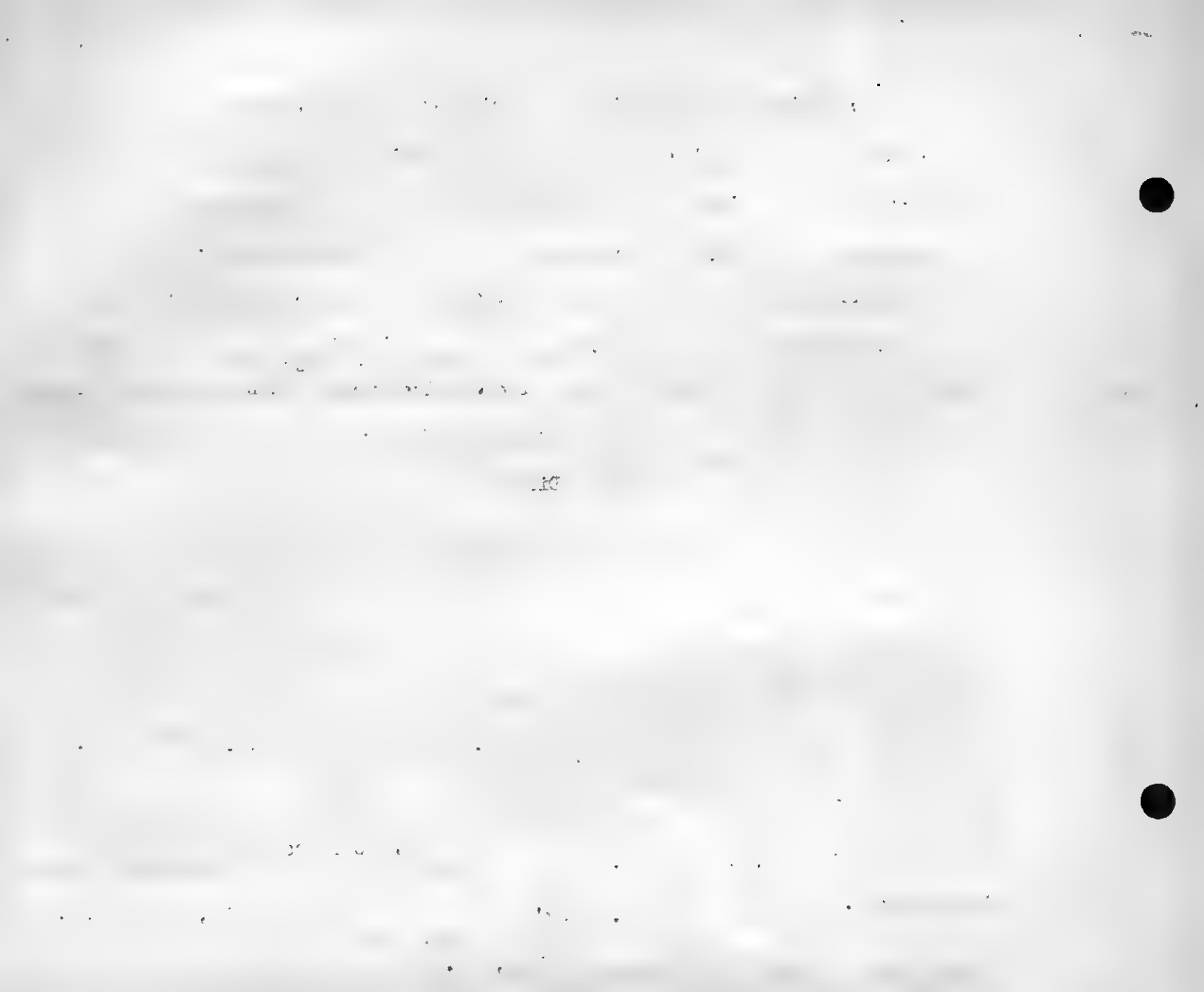
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b. HOUR		
James Daniel CRESSEY JR						January Month Day 13 Year 69		1155 AM		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Caucasian		July 25, 1946		22 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Maine		USA				Montgomery		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				
Bethesda			Naval Hospital			Marine Corps				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maine					Brunswick		YES <input type="checkbox"/> NO <input type="checkbox"/>		Brickford Road	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
James Daniel CRESSEY, SR			Alice Rebecca WEBSTER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address					
yes			1967-68		004 447 799 Marine Corps Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Quadraplegia										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Gunshot wound to neck										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year		Accidentally shot by a M-16 rifle						
		P.M. Dec. 13 1968								
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		in country		Republic of Viet Nam						
22a. I certify that XX (this hospital) attended the deceased from Dec. 23, 1968, to Jan. 13, 1969, that XX (we) last saw the deceased alive on Jan. 13, 1969, and that in MY (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) not view the body after death										
22b SIGNATURE					22c DATE SIGNED					
Lawrence J. Merz					Jan. 14, 1969					
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
LAWRENCE J. MERZ					Naval Hospital, Bethesda, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		1-16-69				BRUNSWICK MAINE				
24 FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
W. W. Chambers Co. ADDRESS					JAN 20 1969		[Signature]			
1400 Chapin Street, N. W. Washington, D. C.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01047 CERTIFICATE OF DEATH 01042											
1. DECEASED NAME (Type or print) Veronica Cecelia Crimmins						2a. DATE OF DEATH Month January Day 2 Year 1969			2b. HOUR 11:15A		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4 July 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 70 DAYS 00 HOURS 00 MIN.		IF UNDER 24 HRS. HOURS 00 MIN.	
7a. BIRTHPLACE (State or foreign country) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) telephone operator			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Connecticut			13b. COUNTY New Britain		13c. CITY OR TOWN New Britain		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 83 Grove Hill		
14. FATHER'S NAME First Patrick Middle Hasson Last Nellie				15. MOTHER'S MAIDEN NAME First Nellie Middle Rourke							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO 040-05-7983		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (pulmonary fibrosis) DUE TO, OR AS A CONSEQUENCE OF (b) Hodgkin's Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 1 Year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from Nov. 1 , 19 68 , to Jan. 2 , 19 69 , that (we) lost saw the deceased alive on January 2 , 19 69 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE Robert E. Curran		22c. DATE SIGNED 3 January 1969		22d. PHYSICIAN'S NAME (Type) Robert E. Curran, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/7/69		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City or Town) (County) (State) New Britain, Conn.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		1331 Rockville Pike		REC'D BY REGISTRAR Jan 7 1969		25b. REGISTRAR'S SIGNATURE Julian Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

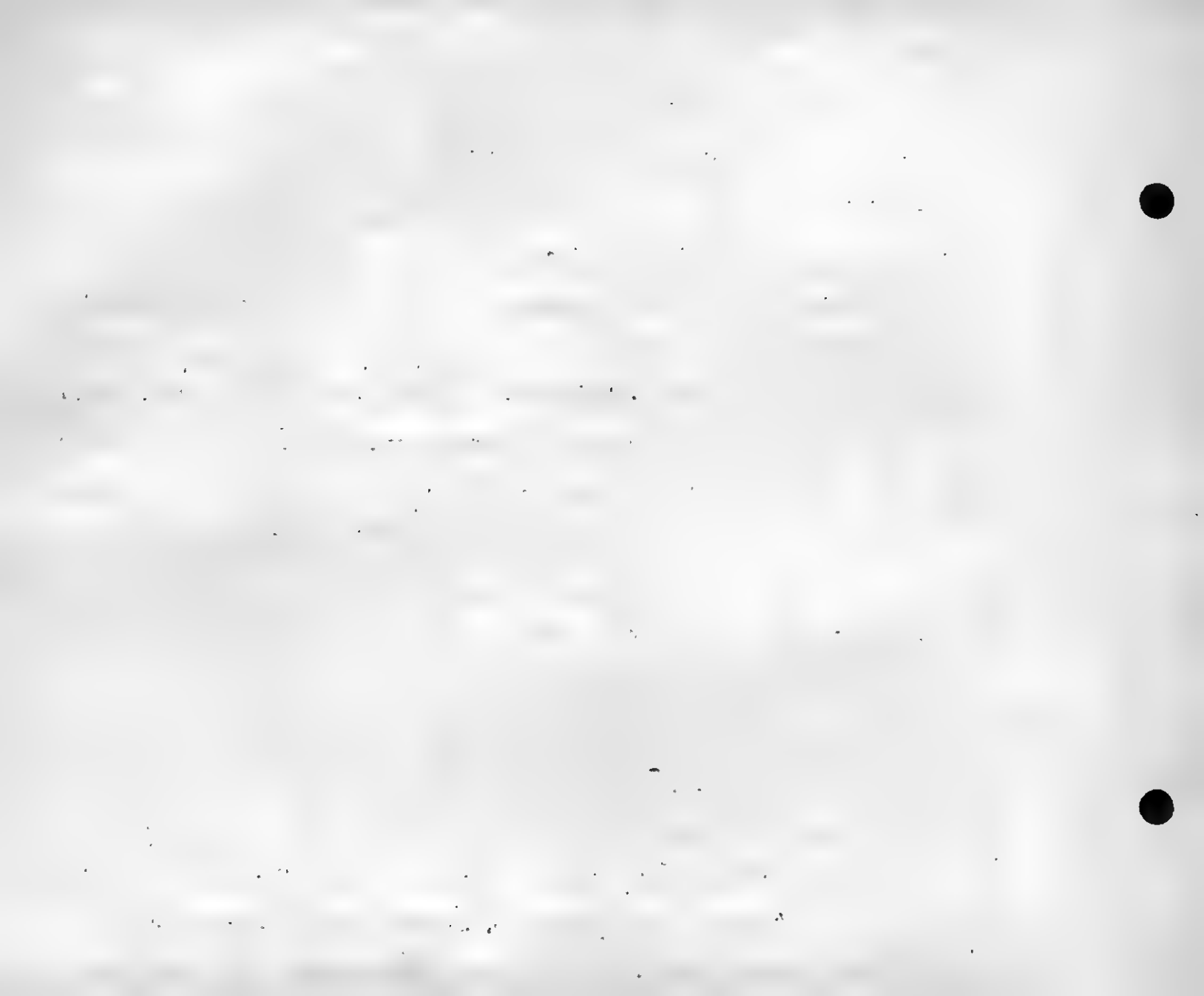
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) <i>John Edgar Crown</i>			2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> Jan 9 1969			2b. HOUR 7 P M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Feb 8, 1915</i>	6. AGE (in years as of birthday) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD <i>Feb 9</i> Day Year <i>1969</i>		2d. HOUR 7 P M	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>?</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission only) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>12616 Monroe St.</i>	
14. FATHER'S NAME First <i>Richard</i> Middle <i>Crown</i> Last <i>Crown</i>			15. MOTHER'S MAIDEN NAME First <i>Grace</i> Middle <i>Bean</i> Last <i>Bean</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		(If yes give year or dates of service) <i>WW II</i>		16b. SOCIAL SECURITY NO <i>213-01-1717</i>		17. INFORMANT <i>Dennis Crown-Son</i>		ADDRESS <i>Rt 2 Araby Rd. Frederick, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Injuries, multiple, severe, due to automobile accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>7 P M Jan 9 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Struck by Auto when crossing Highway</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f. LOCATION Street or R.F.D. No. <i>705 nur-feld Rd.</i>		City or Town <i>Rockville</i>		County <i>Montgomery</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>			M.D. <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Jan-10-1969</i>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>Gaithersburg, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/13/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>		23d. LOCATION (City or Town) <i>Gaithersburg, Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>				1331 <i>Rockville Pike</i> <i>Rockville, Md.</i>		25a. REC'D BY REG STRAR <i>JAN 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Anna Middle Mildred Last Cumbow			2a. DATE OF DEATH Month January Day 22 Year 1969			2b. HOUR PM 3:30 AM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 10 December 1909		6. AGE (In years lost birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE West Virginia		13b. COUNTY Beckley		13c. CITY OR TOWN Beckley		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1310 S. Kanawha Street	
14. FATHER'S NAME First Albert Middle Starks Last			15. MOTHER'S MAIDEN NAME First Bertha Middle McBrier Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give year or dates of service) --		16b. SOCIAL SECURITY NO. Not Available		17. INFORMANT Bethesda, Maryland 20814 The Medical Records, The Clinical Center.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4109</u> arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension, intractable ventricular /</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (d) <u>Old myocardial infarction</u> (e) <u>Arteriosclerotic coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION Jan. 22, 1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>13 January, 1969</u> to <u>22 Jan., 1969</u> , that (we) last saw the deceased alive on <u>22 January 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edward Jacobs, Jr., M.D.</u> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 23 January 1969			
22d. PHYSICIAN'S NAME (Type) Edward Jacobs, Jr., M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/27/69		23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Beckley, West Virginia			
24. FUNERAL DIRECTOR Washington Metropolitan Funeral Service Box 1195 Falls Church, Virginia				25a. REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~the~~ pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 12-1-69
45M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) First Middle Last Ellen Jeffers Davis			2a DATE OF DEATH Month Day Year 1 26 1969			2b HOUR 3 15 P M			
3 SEX F		4 RACE W		5 DATE OF BIRTH 4-16-17		6 AGE (In years last birthday) 51 YRS		7 UNDER 1 YEAR MONTHS DAYS 9 10	
7a BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b COUNTY PG Co.		13c CITY OR TOWN T.Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7105 New Hamp. Ave.	
14 FATHER'S NAME First Middle Last Lyndon B. Jeffers			15 MOTHER'S MA DEN NAME First Middle Last Annie Norton						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) (If yes give war or dates of service) No --			16b SOCIAL SECURITY NO yes		17 INFORMANT Norton L. Jeffers Address 2141 9 St., N.W., D. C.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (b) arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 week			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day - Year P.M. -19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1965, to Jan 26, 1969, that (I) (we) lost saw the deceased alive on Jan 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Samuel J. Sugar MD				22c. DATE SIGNED Jan 26, 1969		22d. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR			
22e ADDRESS 4637 EASTERN AVE WASH DC 20018									
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1-27-1969		23c NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland			
24 FUNERAL DIRECTOR Paul J. Smith Warner E. Pumphrey, Inc. 8434 Georgia Avenue				25a REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

Davis, John Ralph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Coroner Notified and Approved

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) John Ralph Davis						2a. DATE OF DEATH Month January Day 7 Year 1969			2b. HOUR 4:10 A		
3. SEX Male		4. RACE Caucas		5. DATE OF BIRTH 7-17-1885		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) Coperson Pa		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Count Md.					
10. CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S.N. 901 Creek Dr		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil Sp		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8811.Colesville rd			
14. FATHER'S NAME First Allen S. Middle avis Last avis				15. MOTHER'S MAIDEN NAME First Bally Middle Titlow Last Titlow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 107-03-0919		17. INFORMANT Address John R Davis jr 14507.Fairacres rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thromboses, recurrent 4. 17 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Generalized arteriosclerosis (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years Several years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of right femur; diverticulosis of colon, multiple, bleeding											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from 1954 , to Jan 7 , 1969, that (I) (we) last saw the deceased alive on January 2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bennet A. Porter Jr.		DEGREE PHYS.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED January 7, 1969					
22d. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.		22e. ADDRESS 9301 Colesville Rd., Silver Spring, Md.									
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE 1.7.69		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City or town) (County) (State) Washington D C					
24. FUNERAL DIRECTOR Lee Funeral Home.300.4th st N E				ADDRESS		25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabs on pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
0105. CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Ervin Leonard Day						2a. DATE OF DEATH Month Day Year 1 14 1969			2b. HOUR M		
3 SEX Male		4. RACE White		5. DATE OF BIRTH 7-7-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Potomac Valley			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labor			12b. KIND OF BUSINESS OR INDUSTRY Labor		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Mont.			13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8124 Snuffer School	
14. FATHER'S NAME First Middle Last Joseph F. Day				15. MOTHER'S MAIDEN NAME First Middle Last Drucella Ingalls							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. Catherine May				same as 139	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF (c) —											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCAT ON Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-16-69 , 19 69 , to 1-14 , 19 69 , that (I) (we) last saw the deceased alive on 1-12 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. J. Luel						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) L. J. Luel M.D.						22e. ADDRESS Gaithersburg, Md.					
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 1-16-69		23c. NAME OF CEMETERY OR CREMATORY Goshen		23d. LOCAT ON (City or Town) (County) (State) Goshen Mont. Md.					
24. FUNERAL DIRECTOR ADDRESS Francis H. Barber Laytonsville, Md. 20760						25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

15 - 1

Adding thing on pg. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01053

1968

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) WILLIAM E DAY			2a. DATE OF DEATH Month JAN Day 1 Year 1968			2b. HOUR 6:55 AM							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 12/28/11		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS 20 DAYS 3		IF UNDER 24 HRS HOURS MIN 			
7a. BIRTHPLACE (State or foreign country) KY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY							
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PAINTER				12b. KIND OF BUSINESS OR INDUSTRY N.O.L.	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13200 FWOOD LANE			
14. FATHER'S NAME First BERT Middle DAY Last DAY				15. MOTHER'S MAIDEN NAME First WINIFRED Middle WILDER Last WILDER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) (25-32-42-45)				16b. SOCIAL SECURITY NO 		17. INFORMANT HELEN DAY - WIFE				Address 			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Uremia													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) Tubular necrosis, right kidney													
DUE TO, OR AS A CONSEQUENCE OF													
(c) 													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12/8/68 , 19 , to 1/1/69 , 19 , that (I) (we) last saw the deceased alive on 12/8/68 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Henry C. Scruggs						22c. DATE SIGNED 1/1/69			22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs				
22e. ADDRESS 						22f. ADDRESS 							
23a. BURIAL - CREMATION REMOVED (Specify)			23b. DATE 1-4-69			23c. NAME OF CEMETERY OR CREMATORY Parklawn			23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.				
24. FUNERAL DIRECTOR Robert A. Pumphrey						25a. REC'D BY REGISTRAR JAN 9 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				
25c. ADDRESS 7557-Wisconsin Ave., Bethesda, Md.													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Robert Augustine Dillon, Sr.					2a. DATE OF DEATH Month Jan Day 12 Year 1969		2b. HOUR 1:15 PM		
3 SEX male		4. RACE white		5. DATE OF BIRTH 2/10/07		6. AGE (In years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Information Officer U.S. Treasury Dept.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if he institut an residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5208 Edgemoor Lane	
14. FATHER'S NAME First Matthew Middle A. Last Dillon			15. MOTHER'S MAIDEN NAME First Edith Middle Bennett Last Bennett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 216-44-4301		17. INFORMANT JULIANE Dillon - wife - add same Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarct I-V Septum									
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 18, 1964 , to Jan 12, 1969 , that (I) (we) last saw the deceased alive on Jan 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d.d) (d.d not) view the body after death.									
22b. SIGNATURE Robert A. Pumphrey DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 12/26/69				
22d. PHYSICIAN'S NAME (Type) Robert A. Pumphrey					22e. ADDRESS 4777 Belling Lane Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE 1/14/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery, Sil. Spring Montg.		23d. LOCATION (City or Town) (County) (State) Bethesda, Md.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01055									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
OSCAR			Diskin			1 Month 31 Day 69 Year		11:10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
MALE		WHITE		18 88		80 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
RUSSIA		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSP		GROCER (RETD)		FOOD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
FLA		DADE		MIAMI BEACH				800 COLLINS AVE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
ABRAHAM			DISKIN			FRIEDA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO		265 78-6538		SARAH DISKIN		SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
519.2 IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease + aspiration.									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Arteriosclerotic Cardiovascular Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-17, 1968, to 1-31, 1969, that (I) (we) last saw the deceased alive on 1-30-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Bernard A. Heckman, M.D.				Jan. 31, 1969					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Bernard A. Heckman, M.D.				8107 Eastern Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2-2-1969		N.T. NEED CEM		MIAMI FLA.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
GOLD BERG FUNERAL HOME 4217 9th St. N.W.				FEB 4 1969		M. J. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-5-61
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01050

01051

1 DECEASED-NAME (Type or print) BEN			First	Middle	Last	2a DATE OF DEATH Month 1 Day 9 Year 1969			2b. HOUR 1:48 M		
3. SEX Male		4 RACE white		5 DATE OF BIRTH 5-1-94		6. AGE (In years lost birthday) 74 YRS		7. UNDER 1 YEAR MONTHS 1 DAYS 1		8. UNDER 24 HRS HOURS 1 MIN 48	
7a BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery County Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales		12b KIND OF BUSINESS OR INDUSTRY Mod.					
13a USUAL RESIDENCE (Where deceased admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Heaton		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13108 Hillenwood Drive			
14. FATHER'S NAME First John Middle Scott Last Ditto		15 MOTHER'S MAIDEN NAME First Eva Middle Kell Last Richardson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service) --		16b. SOCIAL SECURITY NO 226-46-7576		17. INFORMANT Rev. R. Ditto, Jr.		Address 1100 E. 1st St. Wash. - Ch. h. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MOS 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from SEPT , 1967, to JANUARY 9 , 1969, that (I) (we) last saw the deceased alive on JANUARY 9 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward A. Beeman		M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED JANUARY 9, 1969					
22d. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN		M.D.		22e. ADDRESS 1015 SPRING ST. SILVER SPRING MD 20910							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-11-1969		23c. NAME OF CEMETERY OR CREMATORY Parble Cemetery		23d. LOCATION (City or Town)		(County)		(State)	
24 FUNERAL DIRECTOR Wm. Leo J. J. J.		ADDRESS S.S., Md.		25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE Charles J. J. J.					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

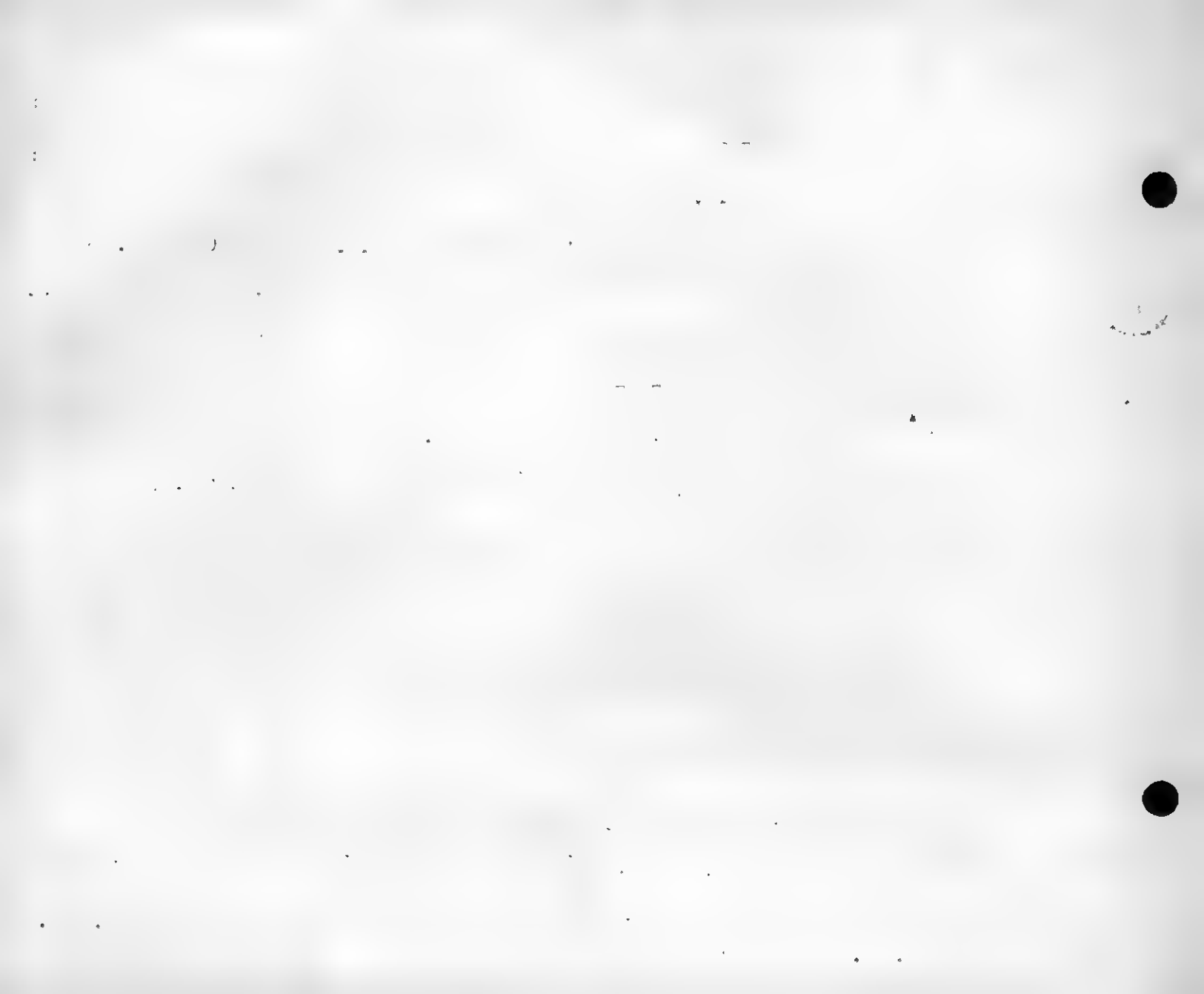
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0105.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1952

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Lex Leon Dodds						DATE ESTIMATED		1	18	1969	10:36 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Day	Year
M	W	11-7-09	59 YRS.	MONTHS DAYS		HOURS MIN.		1		18	1969
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Iowa		U.S.				Montgomery		Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Olney			Montgomery General			U.S. Government - Dept. Army					
13a. U.S. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS. OF CITY LIMITS?		
Md			Montgomery			Silver Spring			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Lute Wallow			Dodds			Iowa			Rose Johnston		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. Eva Lee Dodds			same as above								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				JAN. 19, 1969			
Belden R. Keap M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. B. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				1/22/69				Ft. Lincoln Cemetery			
24. FUNERAL DIRECTOR				ADDRESS				25a. RECEIVED BY REGISTRAR			
The S. H. Hines Company Washington, DC								JAN 23 1969			
								25b. REGISTRAR'S SIGNATURE			
								f. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
31053											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>William C. DORAN</i>						2a. DATE OF DEATH Month <i>JAN</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>5:45</i> AM		
3 SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>5-11-1908</i>		6 AGE (in years last birthday) <i>60</i> YRS.		7 UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>25</i>		7 UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Artist</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>				13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY, TOWN, OR VILLAGE YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>10419 Montrose Ave.</i>	
14 FATHER'S NAME First <i>William</i> Middle <i>DORAN</i> Last <i>CLARK</i>				15. MOTHER'S MAIDEN NAME First <i>GRACE</i> Middle <i></i> Last <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO <i>365-22-4884</i>		17 INFORMANT Address <i>DONNA DORAN - WIFE - SAME</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. <i>1621</i> IMMEDIATE CAUSE (a) <i>METASTATIC MELANOMA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>PULMONARY CA.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN</i> , 19 <i>68</i> , to <i>JUN</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>DEC 27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>J.P. McCarrick M.D.</i> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-6-69</i>			
22d PHYSICIAN'S NAME (Type) <i>J.P. McCarrick M.D.</i>						22e ADDRESS <i>809 Viers Mill Rd., Rockville MD</i>					
23a BURIAL CREMATION <i>CREMATION</i> (Specify)		23b. DATE <i>1-10-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>				23d LOCATION (City or Town) (County) (State) <i>Rockville Montgomery Md.</i>			
24 FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> 7557-Wisconsin Ave., Bethesda, Md.						25a REC'D BY REGISTRAR <i>JAN 9 1969</i>		25b REGISTRAR'S SIGNATURE <i>William J. Jones</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> C1053 CERTIFICATE OF DEATH 31054 </div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
LEWIS			W			DORSET			January Month 7 Day 1969 Year 5 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. FUNERAL YEAR MONTHS DAYS 8. YRS.	
male		Caucasian		11-23-1899		69			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		United States				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			7701 Westfield Drive			Navy Dept.			U.S. Govt
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Montgomery			Bethesda		7701 Westfield Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Charles Otis Dorset			Sue Tompkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			216 44 7622		Thelma T. Dorset. Wife, same as item #13				
18. CAUSE OF DEATH (Enter only one cause per Part 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>8-9 years</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary Emphysema + Fibrosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 1963, to <u>JAN</u> , 1969, that (I) (we) last saw the deceased alive on <u>5 JAN</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. F. Cresswell Jr. M.D.</u> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7 Jan 1969</u>			
22d. PHYSICIAN'S NAME (Type) W. F. Cresswell Jr., M.D.				22e. ADDRESS 2029 Q St. N.W., Wash., D.C.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-10-1969		Parklawn Cemetery		Rockville, Montgomery Co., Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRATION NUMBER			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1055

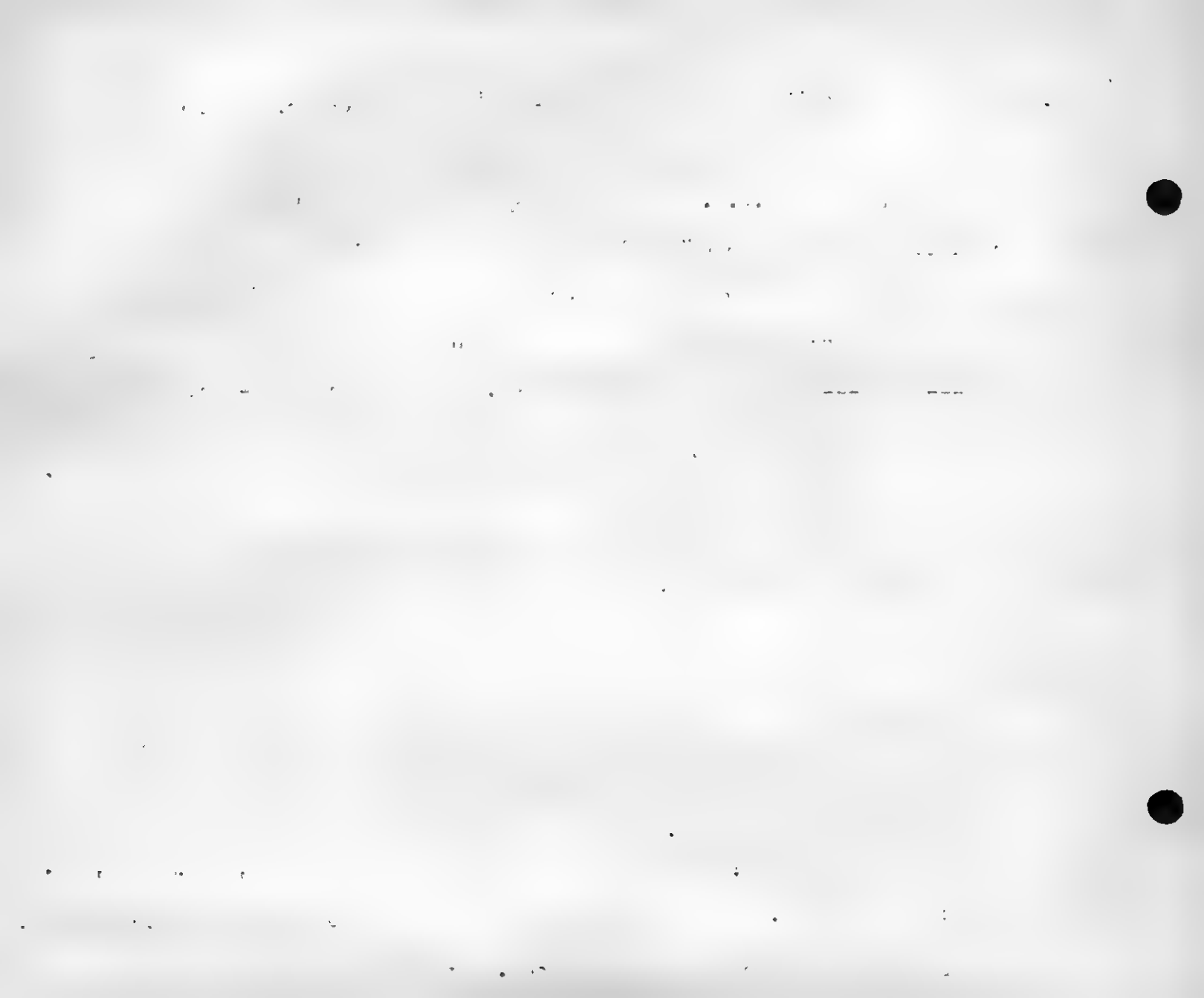
01060

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>25 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>120 Lexington Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if not within Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>120 Lexington Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace Breuninger Dove</u>		4. DATE OF DEATH <u>Jan. 17 1969</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 1885</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry F. Breuninger</u>		14. MOTHER'S MAIDEN NAME <u>Annie Katherine Love</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>523 12 1826</u>	
17. INFORMANT <u>Shirley Forrest (Daughter)</u>		Address <u>same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (a), stating the underlying cause last. (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1953</u> to <u>Jan. 17, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17, 1969</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>Jan 17, 1969</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		22d. ADDRESS <u>345 University Blvd., W Silver Spring, Md.</u>	
23a. DEATH CERTIFICATE NO. <u>1-22-1969</u>		23b. DATE THEREOF <u>Jan 17, 1969</u>	
23c. LOCAL HEALTH OFFICER'S SIGNATURE <u>W. H. D. C.</u>		23d. LOCAL HEALTH OFFICER'S NAME <u>W. H. D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. D. C.</u>		24b. NAME OF FUNERAL HOME <u>W. H. D. C.</u>	
25a. REC'D BY REGISTRAR <u>Jan 24 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Jan 24 1969</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Kamila			Dropiowski			January 13 1969			M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		8/11/78			90 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Poland		U.S.A.					Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville			6433 Tuckerman Lane			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Montgomery		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6433 Tuckerman Lane			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
Juljusz Gasiorowski				Antonia Wallock								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
						Rev. Gaither Warfield - son in law same item #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Myocardial Infarction										48 hrs		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										96 hrs		
(b) Coronary Thrombosis												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Coronary Atherosclerosis										10 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
Ca of colon -												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1/30, 1962 to 1/13, 1969, that (I) (we) last saw the deceased alive on 1/10/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Stephen N. Jones										1/14/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Stephen N. Jones						809 Viers Mill Road, Rockville, Md.						
23a. BURIAL, CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial		1/16/69		Rockville				Rockville Montgomery Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE		
Tyson Wheeler Funeral Home 1331 Rock Pike						JAN 16 1969						
Rockville, Maryland												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours of death.

VR-103
304 REV. 11-58

01062

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) DUDLEY		First B.	Middle	Last LEONEA	2a. DATE OF DEATH Month 1 Day 24 Year 69		2b. HOUR 7:45AM				
3. SEX Fem		4. RACE NEGRO		5. DATE OF BIRTH 7-27-87		6. AGE (In years lost birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NORFOLK Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONIGOMERY Md.					
10. CITY OR TOWN OF DEATH WHEATON Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.N.H. 901 ARCOLA AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ph.D. in ENG. & DRAMA		12b. KIND OF BUSINESS OR INDUSTRY Schools					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY 13b COUNTY		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1629 Columbia Rd. N.W.			
14. FATHER'S NAME First Unknown Middle Last				15. MOTHER'S MAIDEN NAME First Unknown Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO (If yes give year or dates of service) None		16b. SOCIAL SECURITY NO		17. INFORMANT DR. J. H. Satterwhite		Address 1814 Tanapack St. N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C2 of colon 538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 7-6-1967 , to 1-24-1969 , that (I) (we) last saw the deceased on 1-24-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/24/69		
22d. PHYSICIAN'S NAME (Type) A					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/27/69		23c. NAME OF CEMETERY OR CREMATORY Lincoln		23d. LOCATION (City or Town) Suitland		(County)		(State)	
24. FUNERAL DIRECTOR Rhine Funeral Home 311 N. 2nd St					ADDRESS		25a. REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print) <i>Bobby Louise Surey</i>						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 1-21-69			2b HOUR 10:00 AM			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>1-4-26</i>		6 AGE (in years last birthday) <i>43</i> YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a SOCIAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution, admission) STATE <i>Md.</i>				13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4400 East West Highway</i>		
14 FATHER'S NAME First <i>Herman</i> Middle <i>Richardson</i> Last <i>Bess</i>				15 MOTHER'S MAIDEN NAME First <i>Bess</i> Middle <i>Gray</i> Last <i>Gray</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>				16b SOCIAL SECURITY NO <i>403-34-0036</i>		17 INFORMANT <i>Greg J. Surey - Son</i>			ADDRESS <i>Same</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Crushed Chest.</i>										<i>Sudden.</i>		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Trunk from Fall - 11 Stories</i>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year <i>10:30 PM Jan 21 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Jumped from Window 11th floor</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Apartment</i>		21f. LOCATION Street or RFD No <i>4400 East West Hwy.</i> City or Town <i>Bethesda</i> County <i>Montgomery</i> State <i>Md.</i>								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>Jan 21 1969</i>				
EXAMINER'S NAME (Type) <i>John G Ball</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
				ADDRESS (Street, city, town or county) <i>Montgomery Co., Maryland.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/24/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cemetery, Arlington, Virginia</i>				23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. RECD. BY REGISTRAR <i>JAN 27 1969</i>				25b. REGISTRAR'S SIGNATURE <i>Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First HENRIETTA			Middle DUVALL			Last DUVALL			2a DATE OF DEATH Month Day Year JAN 7 1967			2b HOUR 12:45 PM		
3 SEX FEMALE			4 RACE NEGRO			5 DATE OF BIRTH 6/13/02			6 AGE (In years last birthday) 66 YRS			7 UNDER 1 YEAR MONTHS DAYS			7 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery								
10 CITY OR TOWN OF DEATH BETHESDA			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) domestic			12b KIND OF BUSINESS OR INDUSTRY private								
13a U.S.A. RESIDENCE (Where deceased lived, if institut an Resedence before admiss an) STATE MARYLAND			13b COUNTY MONTGOMERY			13c CITY OR TOWN ROCKVILLE			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 10741 Seven Lakes Rd.					
14 FATHER'S NAME First Middle Last Henry Lancaster			15 MOTHER'S MA DEN NAME First Middle Last Martha														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b SOCIAL SECURITY NO 215-26-3669			17 INFORMANT Francis Palmer			Address H. Lancaster								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory obstruction</u>												2 min					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>																	
19a DATE OF OPERATION <u>None</u>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>12:26</u> , 19 <u>65</u> , to <u>11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>11</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>E. Levin</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>12/18/69</u>								
22d. PHYSICIAN'S NAME (Type) E. LEVIN			22e. ADDRESS 8218 Wisconsin Ave														
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 1-5-69			23c NAME OF CEMETERY OR CREMATORY FISHERMAN'S CEMETERY			23d LOCATION (City or Town) (County) (State) ROCKVILLE, MONTG. MD								
24 FUNERAL DIRECTOR <u>Bernie R. Snowden</u>			ADDRESS Rockville			25a REC'D BY REGISTRAR JAN 8 1969			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

304 REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Mamie Alice Duvall			2a. DATE OF DEATH Month January Day 24 Year 1969			2b. HOUR P 11:45 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12/25/86		6. AGE (in years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Mdse.			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIM TSY YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 27209 Ridge Road	
14. FATHER'S NAME First William Middle E. Last Watkins			15. MOTHER'S MAIDEN NAME First Fannie Middle L. Last Hyatt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 218-34-3692		17. INFORMANT Records Address Montgomery General Hospital, Olney, Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week - 15 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (has has not) attended the deceased from 2/18 , 19 47 , to 1/24 , 19 69 , that (I) (do do not) saw the deceased alive on 1/24 , 19 69 , and that in (my) (our our) opinion death occurred on the date and hour and from the causes stated above, (I) (we we) (did did not) view the body after death.									
22b. SIGNATURE James P. Kerr M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/25/69	
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M. D.				22e. ADDRESS Damascus Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		23d. LOCATION (City or Town) (County) (State) Clagettville, Md.			
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR DATE JAN 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10M REV 1/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Do signed with Medical Examiner B. Ray No. - Gledener M.D.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) FREDERICK Fred E. Ellrod		Middle		Lost		2a. DATE OF DEATH Month Day Year JAN 27 1969		2b. HOUR 7³⁰ A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 12-13-1899		6 AGE (In years last birthday) 69 YRS		7 IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md	
10. CITY OR TOWN OF DEATH BRADDOCK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GARDENS SANIT		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if not real) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY RET.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 403 HILLSMERE DRIVE	
14. FATHER'S NAME First Middle Last CHARLES ME ELLROD		15. MOTHER'S M.A.D.E.N. NAME First Middle Last ELIZA. MARY STEIMER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT JESSIE M. ELLROD #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest. 411 DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerosis 5 min years.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Sept , 19 68 , to Jan , 19 69 , that (2) (we) lost the deceased alive on 12/18 , 19 68 , and that in my (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (did not) view the body after death									
22b. SIGNATURE James K Coleman MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/27/69.			
22d. PHYSICIAN'S NAME (Type) JAMES K COLEMAN MD.		22e. ADDRESS 9241 COLUMB. A BLVD		SILVER SPRING.		MARYLAND			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE 1-30-69		23c. NAME OF CEMETERY OR CREMATORY ST. ANNE'S		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.			
24. FUNERAL DIRECTOR John M. Taylor Son Annapolis MD.		ADDRESS		25a. REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE James Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

3106

01063

1. DECEASED-NAME (Type or print) THOMAS H. ETZLER			2a. DATE OF DEATH Month JAN Day 1 Year 1969			2b. HOUR 10:15 A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/30/40		6. AGE (In years last birthday) 28 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY MONT. Co. Sch.	
13a. USLA. RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN OLNEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Samuel A. Etzler		15. MOTHER'S MAIDEN NAME First Middle Last Eleanor Hewes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 220-36-1081		17. INFORMANT Laura - Wife - Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compression brain skull DUE TO, OR AS A CONSEQUENCE OF brain (b) Hypertensive malignant neoplasm DUE TO, OR AS A CONSEQUENCE OF brain (c) Malignant neoplasm, back CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1-2 weeks 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION Dec 9, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED brain tumor		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 3, 1968 , to JAN 1, 1969 , that (I) (we) last saw the deceased alive on Dec 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John T. Hard				DEGREE MD		22c. DATE SIGNED 1-1-69	
22d. PHYSICIAN'S NAME (Type) John T. Hard				22e. ADDRESS 1015 Spring St. Silver Spring, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 1-4-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE Richard Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1066J									
01064									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
John B. FATO						Month Day Year JAN 25 1969		3:20 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		White		Aug. 26, 1900		68 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy		U.S.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring Md		Holy Cross		Retired Barber					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Montgomery		Silver Spring				4232 Isbell Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Fato			Frances Fato						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		578-42-2807		wife: 13 a, b, c, d, e above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia due to nephrosclerosis</u>									1 year
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>									years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20, 1969</u> to <u>1/25, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/25, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>John J. Curry</u>		<u>1/25/69</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
John J. Curry		9801 Georgia Ave Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Entombment		29 Jan. 1969		Fort Lincoln Mausoleum		Bladensburg, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rinaldi Funeral Home		7400 Georgia Ave., NW Washington, DC 20012		JAN 29 1969		<u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First William	Middle	Last Feingold	2a. DATE OF DEATH Month Day Year Jan 7 1969		2b. HOUR 11:15 M
3. SEX M	4. RACE Cauc.	5. DATE OF BIRTH Feb 2, 1884		6. AGE (in years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Mass.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nursing H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY GARNMENT	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Wash., D.C.		13b. COUNTY 13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2120 16th St. N.W.	
14. FATHER'S NAME First Middle Last Saul Feingold		15. MOTHER'S MAIDEN NAME First Middle Last Golda DeKeyser		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Aida Feingold, Wash., D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 1968, to Jan 7, 1969, that (I) (we) saw the deceased alive on Jan 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE WALTER E. GOOZH MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan 7 1969	
22d. PHYSICIAN'S NAME (Type) WALTER E. GOOZH MD		22e. ADDRESS 2309 SHOREFIELD ROAD		WHEATON MD			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 1/9/69		23c. NAME OF CEMETERY OR CREMATORY Bnai Brith Cem.		23d. LOCATION (City or Town) (County) (State) Worcester, Mass.	
24. FUNERAL DIRECTOR B. DANZAKUSKY & SONS 3501 14th St NW		ADDRESS		25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



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Released per Dr. Dr. Kemp 1/30/69 to again 1/30/69
G.M. No. 40
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01071

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01066

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) VIOLA K. FERGUSON			2a. DATE OF DEATH Month JAN Day 22 Year 1969			2b. HOUR 10 P			
3. SEX FEMALE		4 RACE CAUS.		5. DATE OF BIRTH 7/25/1885		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS 10 HOURS 10 MIN.	
7a. BIRTHPLACE (State or foreign country) LAURENCE, KANSAS		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LAUNDRY INSPECTOR CLEANING		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 409 4th St. NW DC. WASHDC.		13b. COUNTY DC.		13c. CITY OR TOWN WASHDC.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER UNKNOWN	
14. FATHER'S NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577-01-9341		17 INFORMANT Rev W.C. Patton 1412 Cottage St. S.W.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CENTRAL NERVOUS SYSTEM METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE COLON DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS, GENERALIZED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROSIS, GENERALIZED									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 1969 , to Jan 22, 1969 , that (I) (we) lost saw the deceased alive on Jan 22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (aid not) view the body after death.									
22b. SIGNATURE Pedro I. Matias, M.D.				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan 22 '69	
22d. PHYSICIAN'S NAME (Type) PEDRO I. MATIAS, M.D.				22e. ADDRESS 4712 Montgomery PL. BELTSVILLE, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-30-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem Ph Cem		23d. LOCATION (City or Town) (County) (State) Landoner Hill Md			
24 FUNERAL DIRECTOR W.H. Chambers & Co.		ADDRESS 1400 Chapin St NW		25a. RECD. BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE John R. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

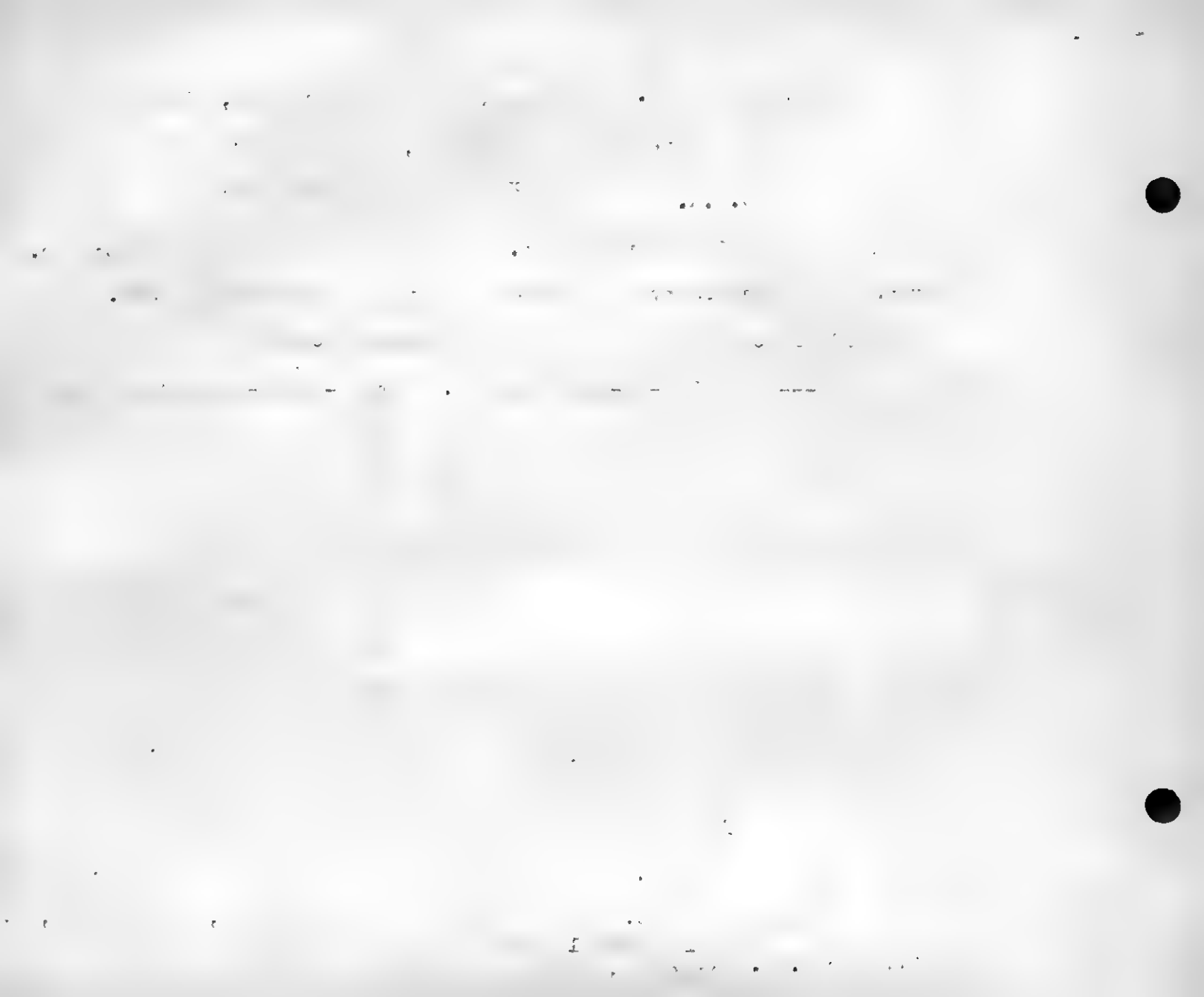
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01072

01067

1. DECEASED-NAME (Type or print) Leland		First L.	Middle Fisher	Lost	2a. DATE OF DEATH January 2, 1969 Year		2b. HOUR M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH April 3, 1891		6. AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 205 Maryland Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) Owner		12b. KIND OF BUSINESS OR INDUSTRY Lumber Co.				
13a. USUAL RESIDENCE (Where deceased admitted) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 Maryland Ave.		
14 FATHER'S NAME First Millard			Middle Fisher			Last Fisher			15 MOTHER'S MAIDEN NAME First Elizabeth	
Middle Fisher			Last Boswell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service) ---			16b. SOCIAL SECURITY NO. 213-10-1994	
17. INFORMANT Erma H. Fisher - wife - same item # 13			Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coverary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Mat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-31-68</u> , 19 <u>52</u> to <u>1-2</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-31-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>D. L. Buley</u>						DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-2-69</u>
22d. PHYSICIAN'S NAME (Type) <u>D. L. Buley</u>						22e. ADDRESS <u>807 Veirs Mill Rd Rockville</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>1/4/69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montgomery, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler F. H. Rockville, Maryland</u>						25a. REC'D BY REGISTRAR <u>JAN 6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 File 109 2/1/69 Items 18 & 22 Film 409 2-20-67 AMS										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01068			
1 DECEASED NAME (Type or Print) REGINA E. FITCH										2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1-29-69										2b HOUR 8:50 P.M.			
3 SEX female		4 RACE white		5 DATE OF BIRTH 12/23/1949		6 AGE (In years last birthday) 49 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c DATE PRONOUNCED DEAD Month 1 Day 29 Year 69										2d HOUR 8:50 P.M.	
7a BIRTHPLACE (State or foreign country) Germany				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.											
10 CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.										12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) bank clerk				12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md				13b COUNTY Mont.				13c CITY OR TOWN Sil.Spr.				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER 9824 Georgia Ave.							
14 FATHER'S NAME First Adolph Middle Scheide Last Frieda										15 MOTHER'S MAIDEN NAME First Frieda Middle Bahr Last Silver Spring													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No				16b SOCIAL SECURITY NO None				17. INFORMANT Sabine D Parks ADDRESS 419 Hillmoor Dr.															
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Spontaneous subarachnoid hemorrhage; DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State															
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Belden R. Keap				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED JAN. 30, 1969															
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.				ADDRESS (City or Town or County)				23a BURIAL, CREMATION OR REMOVAL (Specify) Cremation															
23b DATE 1-31-69				23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d LOCATION (City or Town) (County) (State) Suitland Pr. Geo Md.															
24 FUNERAL DIRECTOR Robert A Pumphrey										25a REC'D BY REG STRAR FEB 3 1969				25b REG STRAR'S SIGNATURE Charles Judge									

158 341

158 341

158 341

158 341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01074

01009

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Edward				Fleming	Jan. 23, 1969		9:20 AM		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 24 HRS.		
Male	Negro		Aug. 3, 1896		72 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Damascus		8300 Gue Rd.		Laborer					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Montgomery		Damascus		YES <input type="checkbox"/> NO <input type="checkbox"/>		8300 Gue Rd.	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
unknown					unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No		217-18-7704		Edward Fleming, Jr.		610 Douglas Ave. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) did not attended the deceased from 12/18, 1962, to 1/23, 1969, that (I) did not saw the deceased alive on 1/16, 1969, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not (did) view the body after death.									
22b. SIGNATURE <u>James P. Kerr, M.D.</u>				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan. 24, 1969	
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				22e. ADDRESS Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 25, 1969		Friendship Meth.		Damascus, Md.			
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 27 1969		25b. REGISTRAR'S SIGNATURE <u>James P. Kerr</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
ERNEST					FLETCHER	Jan. 28, 1969			4:15 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7. IF UNDER 1 YEAR	
Male		Cauc.		Feb. 16, 1899		69 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U. S.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			4400 East-West Highway			U. S. Gov't Emp.		Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Montgomery			Bethesda		4400 East-West Highway	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Robert Fletcher						Annie Stewart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
			174-32-2267			Sister Mrs. Anna E. Walls		Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction									1 hr.
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease									10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 55 to 1-28, 1969, that (I) (we) last saw the deceased alive on 10-8-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sanford J. Randall, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-28-69		
22d. PHYSICIAN'S NAME (Type) SANFORD J. RANDALL					22e. ADDRESS 3001 Veazey Terrace, N. W. Washington, D. C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-31-69		Westminster Cemetery		Philadelphia, Penna.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.					25a. BY REC'D FEB 3 1969		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First JANE	Middle E	Last FLYNN	2a. DATE OF DEATH Month Day Year 1 15 69			2b. HOUR 8:15PM	
3. SEX female		4. RACE White		5. DATE OF BIRTH 1-31-87		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Ridge Road, Box 24929	
14. FATHER'S NAME First Middle Last John O.T. Watkins		15. MOTHER'S MAIDEN NAME First Middle Last Evie Lee King		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no					
16b. SOCIAL SECURITY NO.		17. INFORMANT Address Admission Rec'd., Montgomery Gen. Hospital, Olney							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pyonephrosis and multiple renal calculi</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 28, 1968</i> , to <i>Jan 15, 1969</i> , that (I) (we) last saw the deceased alive on <i>1-15-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederick Moomau</i> M.D.		22c. DATE SIGNED <i>1-16-69</i>			22d. PHYSICIAN'S NAME (Type) Frederick Moomau, M.D.				
22e. ADDRESS <i>Medical Center, Sandy Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <i>Jan. 18, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Upper Seneca Baptist</i>		23d. LOCATION (City or Town) (County) (State) <i>Cedar Grove, Md.</i>			
24. FUNERAL DIRECTOR <i>Olin L. Molesworth</i>		ADDRESS <i>Damascus, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Kenneth J. Hoge</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Peter Calvin Forner						2a. DATE OF DEATH Month 1 Day 4 Year 1969			2b. HOUR 3 P.M.		
3. SEX Male		4. RACE white		5. DATE OF BIRTH 11.25.97		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 8		IF UNDER 24 HRS. HOURS 1 MIN 8	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Mental Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Kirk		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1006 Ashland Drive			
14. FATHER'S NAME First David Middle Forner Last Forner				15. MOTHER'S MAIDEN NAME First Lucille Middle Deshou Last Deshou							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) W				16b. SOCIAL SECURITY NO. 214 46 6793		17. INFORMANT wife + chart + daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY—											
IMMEDIATE CAUSE (a) Carcinoma of the lung											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1968 to Jan 4, 1969 , that (I) (we) last saw the deceased alive on Jan 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Boris RABKIN, M.D.						DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan 4, 1969	
22d. PHYSICIAN'S NAME (Type) Boris RABKIN, M.D.						22e. ADDRESS 1019 University Boulevard, East St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Mercersburg Franklin Pa					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D. BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE James Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
GEORGE PARKER FRALEY						SR		Jan. 3 1969	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		Aug. 11 - 1904		64 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		U.S.A.				Montgomery		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Olney Md.		Brooks Grove Foundation		Gen. Hauling		Trucking			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.		Montgomery		Derwood				6821 Garrett Rd	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Thomas								Helen Alice Blake	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No		219 01 8160		Ruby S. Fraley		Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 wk	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Cirrhosis (Hepatic Coma)				1 month	
		(c)		Cirrhosis				10 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCAT ON Street or R.F.O. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from Oct 1946, to Jan 3 1969, that (I) (we) last saw the deceased alive on Dec 19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (aid not) view the body after death.									
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e ADDRESS		22d. DATE SIGNED			
William S. Murphy		615 Montgomery Ave		Rockville Md		4 Jan 69			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCAT ON (City or Town) (County) (State)			
Burial		Jan. 6 1969		St. Lukes		Derwood Mont. Md.			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Francis H. Barber		JAN 8 1969		Francis H. Barber					

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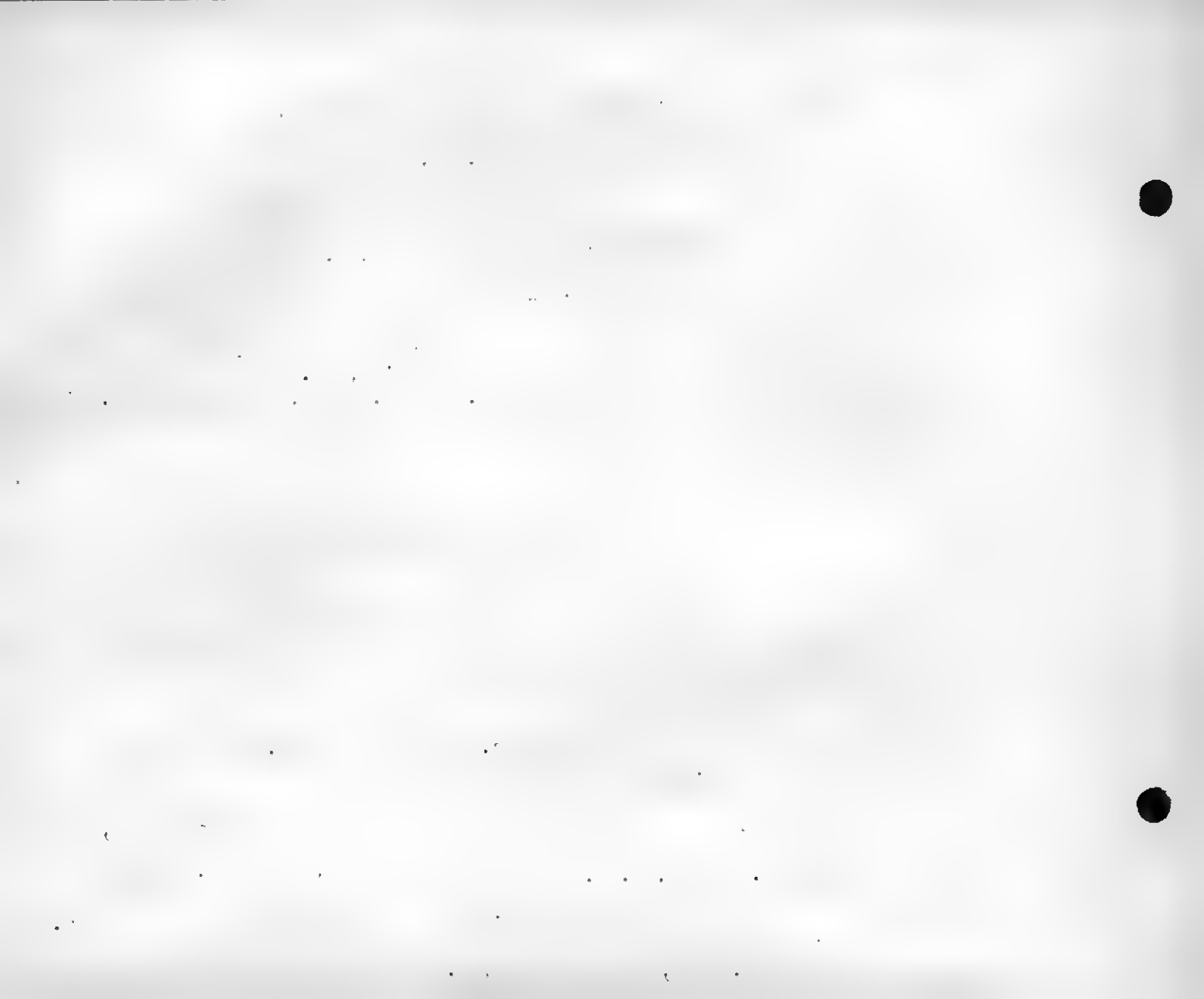
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First Freeman	Middle Eicher	Last FRANK	2a DATE OF DEATH Jan, Month 3rd, Day 1969			2b HOUR 120A M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH Jan. 30, 1901		6 AGE (In years last birthday) 67 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			10c			
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Naval Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery Silver Spring		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1609 Myrtle Road				
14 FATHER'S NAME First Middle Last Harry Lindley FRANK			15 MOTHER'S MAIDEN NAME First Middle Last Maud FREEMAN									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) Yes			16b SOCIAL SECURITY NO 213 46 9580		17 INFORMANT Spring, Md. Address Mrs. Edna M. Frank, 1609 Myrtle Rd. Silver							
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) _____ stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Dec. 27 , 19 68 , to Jan. 3 , 19 69 , that (X) (we) last saw the deceased alive on Jan. 3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.												
22b SIGNATURE <i>Charles S. Crummy M.D.</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED January 3, 1969				
22d PHYSICIAN'S NAME (Type) Charles S. Crummy, M. D.						22e ADDRESS Naval Hospital, Bethesda, Maryland						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 1-7-69		23c NAME OF CEMETERY OR CREMATORY Arlington National			23d LOCATION (City or Town) (County) (State) Arlington Va.					
24. FUNERAL DIRECTOR Collins Funeral Home						25a REC'D BY REGISTRAR DATE JAN 7 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
500 University Blvd. West, Silver Spring, Md.												



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) BERTHA			First Middle Last MATILDA FRANSKO			2a. DATE OF DEATH 1 Month 16 Day 69 Year			2b. HOUR 9:45 P M		
3 SEX Female			4. RACE White			5. DATE OF BIRTH 10-26-02			6. AGE (In years lost birthday) 66 YRS.		
7a. BIRTHPLACE (State or foreign country) Kansas			7b. CIT. ZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Howard			13c. CITY OR TOWN Fulton			3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last John Boettcher			15. MOTHER'S MAIDEN NAME First Middle Last Dora			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		
17. INFORMANT Virginia Zeleznik, Fulton Md.			18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF Compensating heart failure (b) Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 yrs 1 yrs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 yrs			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 68 , to 1/16 , 19 69 , that (I) (we) saw the deceased alive on 1/16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE C. H. L. VIGAN			22c. DATE SIGNED 1/17/69			22d. PHYSICIAN'S NAME (Type) C. H. L. VIGAN			22e. ADDRESS SANDY SPRING MD 20860		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Jan 21 1969			23c. NAME OF CEMETERY OR CREMATORY Washington National			23d. LOCATION (City or Town) (County) (State) Washington Va.		
24. FUNERAL DIRECTOR Kenneth J. J. J. J.			24a. REC'D BY REGISTRAR 3/5/69			24b. REGISTRAR'S SIGNATURE Charles J. J.			DATE JAN 27 1969		

MEDICAL CERTIFICATION



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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

3108

31076

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in it <u>Washington</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived, or institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>906 Hamilton Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JACK</u> First Middle Last <u>FREEDMAN</u>		4. DATE OF DEATH Month Day Year <u>January 8 1969</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1898</u> 9. AGE (In years last birthday) <u>70</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Freedman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>160-07-6772</u>	
17. INFORMANT <u>Rabbi Harry Kranz</u>		Address <u>805 Whittington Terrace</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC STANDSTILL</u> DUE TO (b) <u>Acute MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>69</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> 19 <u>69</u> , and that death occurred at <u>9:05A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Allan B. Cohan</u>		22b. DATE SIGNED <u>1/8/69</u>	
22c. PHYSICIAN'S NAME (Type) <u>Allan B. Cohan</u>		22d. ADDRESS <u>13515 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-9-69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Lebanon Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattsville P.G. Md.</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>		25a. REC'D BY REGISTRAR <u>10 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Richard A. Judge</u>

VR A15 (4)
25M 1/67

Medical Examiner notified and approved release
NHE

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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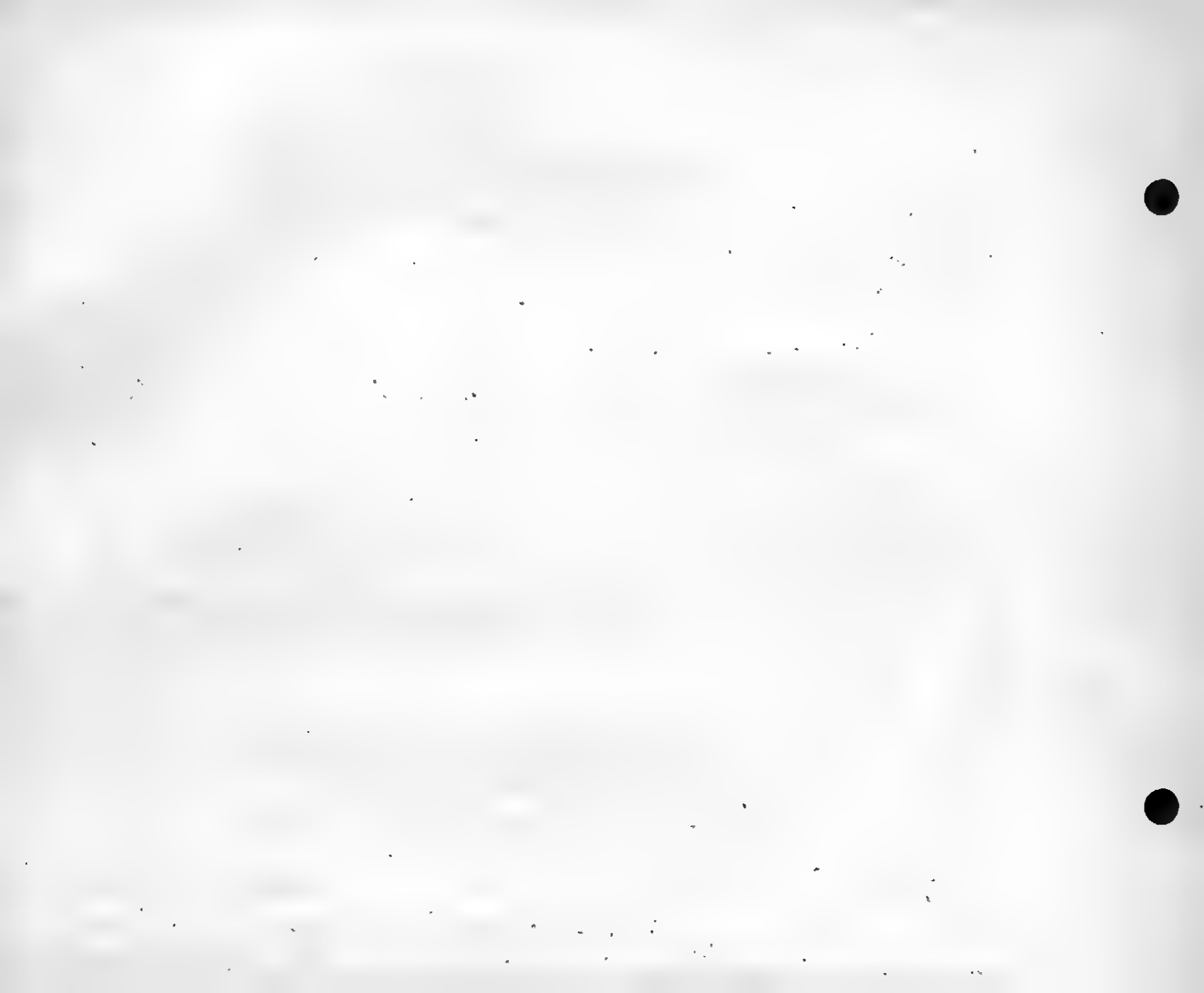
PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>Years</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d STREET ADDRESS <u>1202 Devere Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1202 Devere Drive</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Rebecca Cohen FRIEDMAN</u>		4 DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1969</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Apr. 12 1989</u>
9 AGE (In years lost birthday) <u>79</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b KIND OF BUSINESS OR INDUSTRY <u>-</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Meyer Cohen</u>		14. MOTHER'S MAIDEN NAME <u>Toby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16 SOCIAL SECURITY NO <u>579-22-1883A</u>	
17. INFORMANT <u>MORRIS FRIEDMAN</u>		Address <u>1202 Devere Dr. Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4104</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma ; Cerebral Arteriosclerosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>Fall</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>8 PM Nov. 11 1968</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Silver Spring Mont Md</u>	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1968</u> to <u>Jan 31 1969</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Jan 31 1969</u> , and that death occurred at <u>8:55 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Norman H. Rubenstein</u>		22b DATE SIGNED <u>1/31/69</u>	
22c PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>		22d ADDRESS <u>11161 N.H. Ave Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>FEB. 2, 1969</u>	
23c NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>		23d LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>	
24 FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS</u>		25a RECEIVED BY REGISTRAR <u>FEB 6 1969</u>	
ADDRESS <u>350 F 14th St. N.W. Washington, D.C.</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1078

1 DECEASED NAME (Type or print) Cynthia		First Ann		Middle Fuller		Last Jan.		2a. DATE OF DEATH Month Jan. Day 9. Year 1969		2b. HOUR 4 A. M.	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH 4/29/94		6 AGE (in years last birthday) 74 YRS.		IF UNDER YEAR MONTHS 74		IF UNDER 24 HRS. DAYS 74	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bible Instructor		12b. KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Takoma Park		13c CITY OR TOWN Takoma Park		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7777- Maple Ave. Apt 206			
14 FATHER'S NAME First William		Middle James		Last Fuller		15. MOTHER'S MAIDEN NAME First Nelly		Middle Riddle		Last Fuller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO (If give war or dates of service)		17 INFORMANT Miss Margaret Fuller		Address 7777 Maple Ave. Takoma Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4567 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) multiple CVA											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1965 , to Jan 9th, 1969 , that (I) (we) last saw the deceased alive on Jan 7th 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE R. H. Sandstrom MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-9-69					
22d PHYSICIAN'S NAME (Type) R. H. Sandstrom MD		22e. ADDRESS 7701 Carroll Ave. TK PK, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify) Jan. 13, 1969		23b DATE		23c NAME OF CEMETERY OR CREMATORY Sumner Memorial		23d LOCATION (City or Town) (County) (State) Frederick Md Va					
24 FUNERAL DIRECTOR Sumner Memorial Funeral Home		ADDRESS 254 Carroll St		25a REC'D BY REGISTRAR DATE 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
George C Fultz						Month Day Year		2 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Aug 2-1888		80 YRS	MONTHS DAYS HOURS MIN		Month Day Year		2 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Baltimore		USA		NEVER MARRIED		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban				Retired-Parts Mgr.		Automotive	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - M 15?		13e. STREET AND NUMBER
MD.			Montgomery		Bethesda		YES NO		4620 N. CHELSEA LANE
14. FATHER'S NAME			15. MOTHER'S M A D E N NAME						
Charles E Fultz			Lydia F. Cooper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
No			577-07-0331		Son Charles		above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis Acute									3 M.
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease									years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES NO	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			19						
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner									
ACTUAL SIGNATURE			M.D.			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			JOHN G. BALL			Jan 1, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			1-3-69		Parklawn Cemetery		Rockville, Maryland		
24. FUNERAL DIRECTOR					25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland					DATE JAN 6 1969		James J. Jones		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-105. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

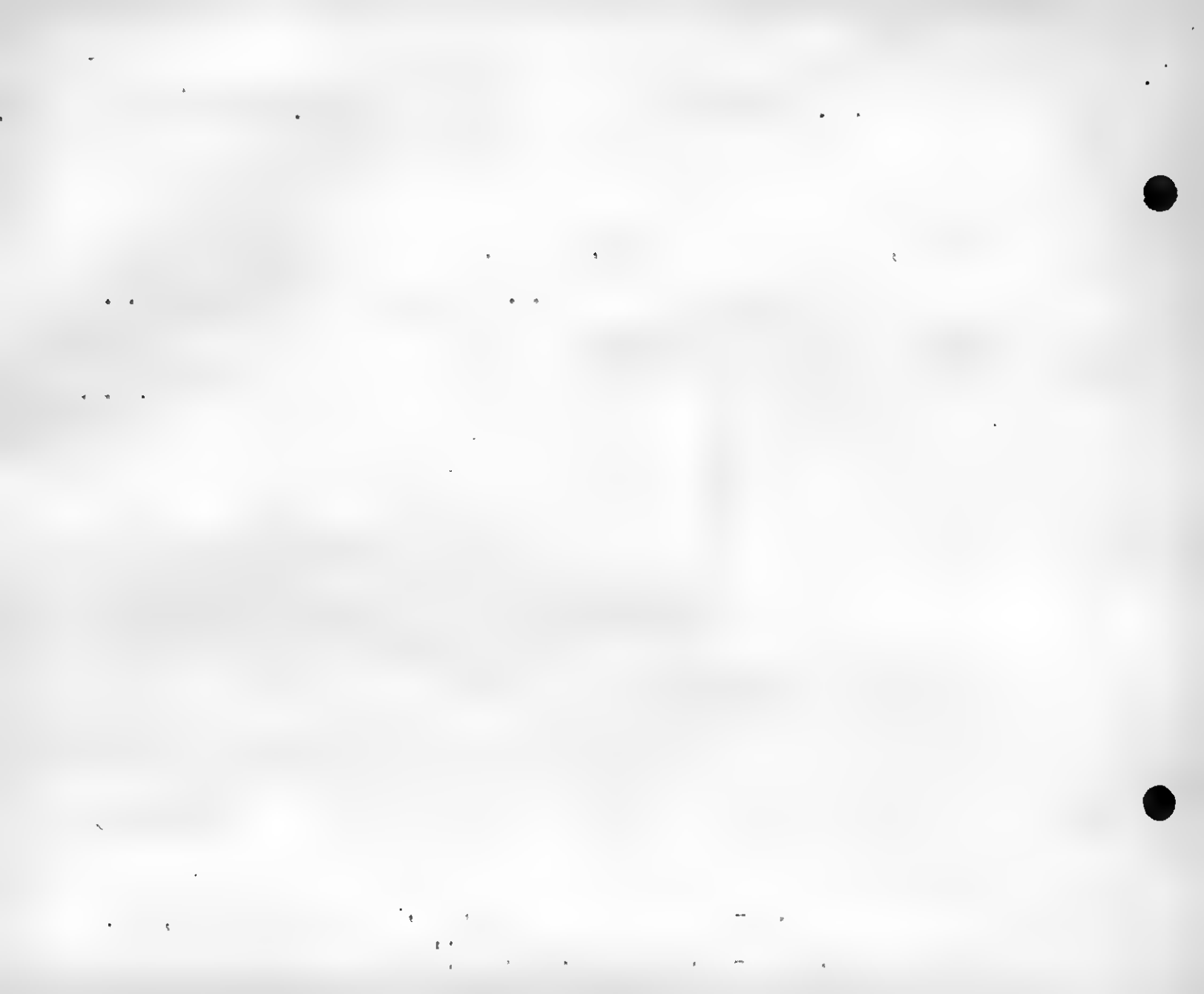
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div> <div>21080</div> <div>1080</div> </div>										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Victoria			C. Galbraith			Month 1/2 Year 69		8:48 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
Female		Cauc.		1/28/01		67 YRS		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED		9. COUNTY OF DEATH		
Belgium			Belgium			WIDOWED NEVER MARRIED DIVORCED		Montgomery Md.		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not regular)		12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Wash. San. & Hosp. Center			Caretaker		Clerk		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		
Md.			Montg.			Hyattsville		YES NO		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		
Tony Anthony			Alice			Unknown		274-32-4835		
17 INFORMANT			17 ADDRESS			17 CITY OR TOWN		17 STATE		
Mrs. Mary Bostic			8123 15th Ave.			Hyattsville		Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonitis, Generalized</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						YES NO				
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19							
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner										
22b. DATE SIGNED			22c. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER							
JAN 3, 1969			Belden R. Reed, M.D.							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)	
Burial			1-7-1969			Mt. Tabor Cemetery			Berkley, West Virginia	
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Warner E. Purnhew, Inc.			JAN 9 1969			Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last LEO, J. GALLENSTEIN						2a. DATE OF DEATH Month Day Year Jan. 3rd 69			2b. HO JR 2:30PM		
3 SEX MALE		4. RACE CAUC		5. DATE OF BIRTH 13 JAN 1901		6 AGE (in years last birthday) 67 YRS		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10 CITY OR TOWN OF DEATH BETHESDA, MD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSP. BETHESDA, MD			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) MILITARY OFFICER, NAVY			12b. KIND OF BUSINESS OR INDUSTRY NAVY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE WASHINGTON			13b. CITY OR TOWN D.C.		13c. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1840 S STREET S.E.				
14 FATHER'S NAME First Middle Last GEORGE GALLENSTEIN				15 MOTHER'S MAIDEN NAME First Middle Last MARY MILLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 577 46 9027		17 INFORMANT Address LIDA M GALLENSTEIN 1840 S STREET, S.E.						
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA											
5321 DUE TO, OR AS A CONSEQUENCE OF STATUS: POST-GASTROENTEROSTOMY AND											
(b) GASTROSTOMY FOR PERFORATED DUODENAL ULCER											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 20 DEC , 19 68 , to 3 JAN , 19 69 , that (I) (we) lost saw the deceased alive on 3 JAN 69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (d.d not) view the body after death.											
22b. SIGNATURE <i>W. P. MORROWA</i> MD DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 04 JAN 69		
22d. PHYSICIAN'S NAME (Type) W. P. MORROWA						22e. ADDRESS USIN BETHESDA, MARYLAND					
23a. BURIAL CREMATION BURIAL		23b. DATE Jan. 7-69		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery			23d. LOCATION (City or Town) (County) (State) Arlington, Va.				
24. FUNERAL DIRECTOR <i>Simmons Bros</i> ADDRESS Simmons Bros. 1661-Gd. Hope Rd. Se. DC						25. REC'D BY REGISTRAR JAN 7 1969			26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 409 Maryland Department of Health
2-11-69 age DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

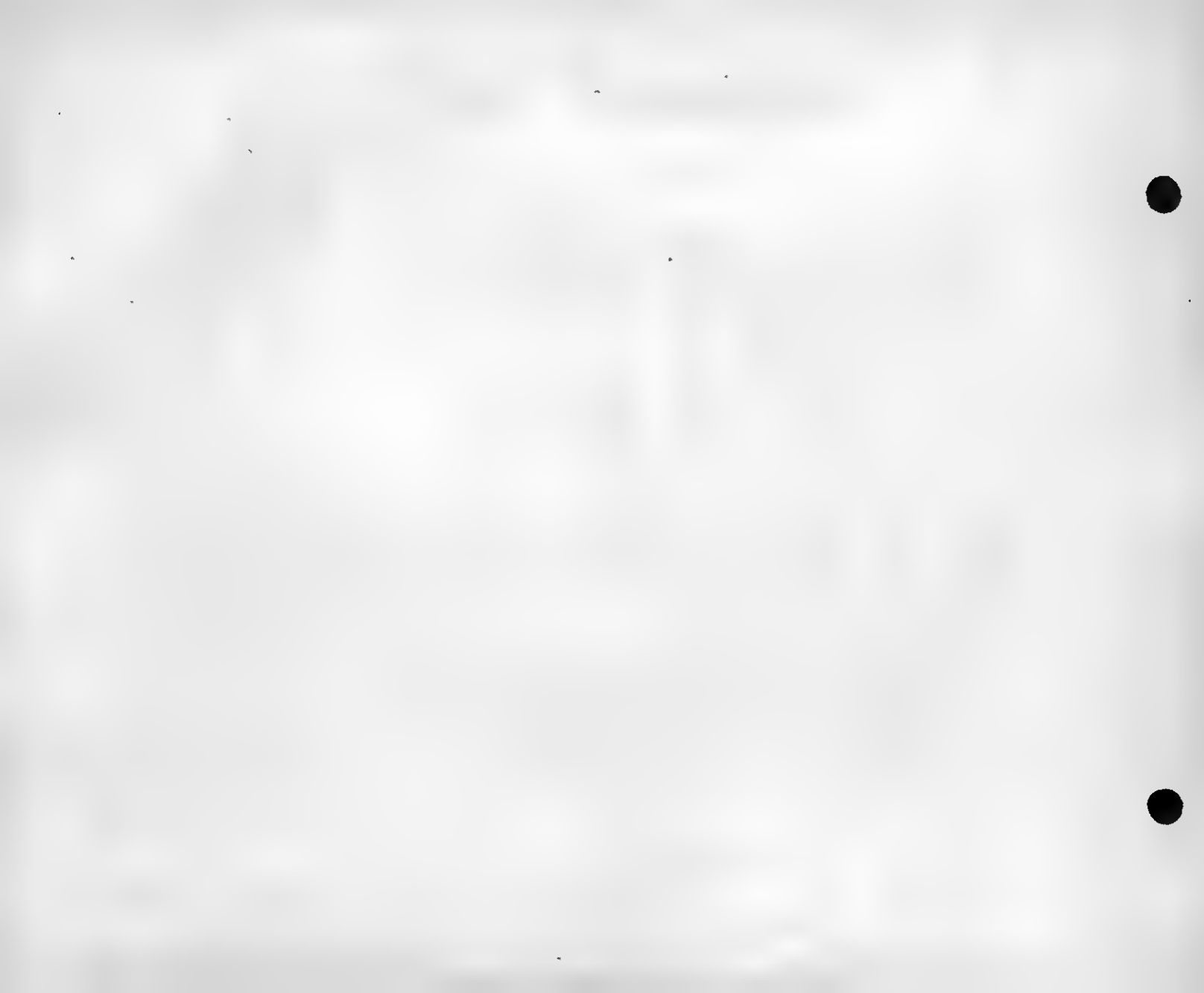
1. DECEASED-NAME (Type or Print) First Middle Last Nebraska Rebecca Gardner			2a. DATE KNOWN OF DEATH Month Day Year 1 - 25 1969			2b. HOUR 3 A M		
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH 11/20/38	6 AGE (in years last birthday) 30 YRS	7 UNDER YEAR MONTHS DAYS 30	8 IF UNDER 24 HRS HOURS MIN 30	2c. DATE PRONOUNCED DEAD Month Day Year January 25 1969		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1321 First Street				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1321 First Street
14 FATHER'S NAME First Middle Last Nelson Cooper			15. MOTHER'S MAIDEN NAME First Middle Last Milo Carroll					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT ADDRESS Father.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound through heart with DUE TO, OR AS A CONSEQUENCE OF exsanguination Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 300 P.M. 1-25 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased shot in chest by male companion				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No Rockville		City or Town Montg.		State Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City or Town, County) Rockville, Md.		22b DATE SIGNED January 25, 1969		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 1-28-69		23c NAME OF CEMETERY OR CREMATORY ST. MARYS CEM.		23d LOCATION (City or Town) (County) (State) Rockville Montg. Md.		
24 FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>		25a. DEC. BY REGISTRAR JAN 30 1969		25b. FILED BY REGISTRAR <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Checked by *[Signature]*

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First <i>Nellie</i>		Middle <i>H.</i>		Last <i>Geiger</i>		2a. DATE OF DEATH Month <i>8</i> Day <i>11</i> Year <i>1968</i>		2b. HOUR <i>5:15 PM</i>
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>11/18/1895</i>		6. AGE (In years last birthday) <i>72</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.				
10 CITY OR TOWN OF DEATH <i>Wheaton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Univ. Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Clerical worker</i>		12b. KIND OF BUSINESS OR INDUSTRY, if any <i>None</i>				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before address an) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Hillandale</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10301 Naglee Rd.</i>		
14 FATHER'S NAME <i>?</i>		First <i>(Unknown)</i>		Middle <i>(Unknown)</i>		Last <i>(Unknown)</i>		15 MOTHER'S MAIDEN NAME <i>?</i> First <i>(Unknown)</i> Middle <i>(Unknown)</i> Last <i>(Unknown)</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>Yes</i>		17 INFORMANT <i>Mr. Robert 'Dad' Geiger</i>		Address <i>1319 E. 1st Place, Wheaton, Md.</i>		
18 CAUSE OF DEATH (Enter any one cause prevailing for (a) (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>										
4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). <i>ASHO</i>										
DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause last. (b) <i>ASHO</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASHO</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>fractured fibula. osteoporosis</i>										
19a. DATE OF OPERATION <i>9/17</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>fractured fibula. osteoporosis</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>9/17</i> , 19 <i>68</i> , to <i>11/11</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>William A. Lender</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> - MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <i>William A. Lender, M.D.</i>		22e. ADDRESS <i>309 Shorefield Road, Wheaton, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-15-1968</i>		23b. DATE <i>1-15-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington Virginia</i>				
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>1319 E. 1st Place, Wheaton, Md.</i>		25a. REC'D BY REGISTRAR <i>Jan 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a US. A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF					
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
20a DATE OF OPERATION			20b CONDITION FOR WHICH OPERATION WAS PERFORMED			20c AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20d IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home farm street factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 7, 1967, to Jan 27, 1969, that (I) (we) last saw the deceased alive on Jan 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			22c DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS		
22b SIGNATURE			22c DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS		
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STRAP			25b REGISTRAR'S SIGNATURE		

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01090

CERTIFICATE OF DEATH

01085

1 DECEASED NAME (Type or print)		First MICHAEL		Middle JAMES		Last GOGGINS		2a. DATE OF DEATH Month JAN Day 5 Year 69		2b. HOUR 1:15A	
3 SEX MALE		4 RACE CAUCASION		5. DATE OF BIRTH 25 JAN 64		6 AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY MARYLAND					
10. CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. HSIOE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7624 DEW WOOD DRIVE			
14. FATHER'S NAME First JOHN Middle F. Last GOGGINS		15. MOTHER'S MA DEN. NAME First MADELEINE Middle ALICE Last MURRAY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address JOHN F. GOGGINS, 7624 DEW WOOD DRIVE							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROSPINAL MENINGITIS DUE TO PNEUMOCOCCUS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (A) (this hospital) attended the deceased from 3 JAN , 19 69 , to 5 JAN , 19 69 , that (H) (we) last saw the deceased alive on 3 JAN , 19 69 , and that in (O) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. K. Howe M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 JAN 69					
22d. PHYSICIAN'S NAME (Type) J. K. HOWE, M.D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-6-69		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) (County) (State) 13705 GA. AVE. SS. MONT. MD.					
24. FUNERAL DIRECTOR W.W. CHAMBERS, J.N.C.		ADDRESS 1400 CHAPIN ST. NW		25a. REC'D BY REG. STRAR JAN 10 1969		25b. REG. STRAR'S SIGNATURE J. Chambers					



permanently to sign certificate by proper record-keeping

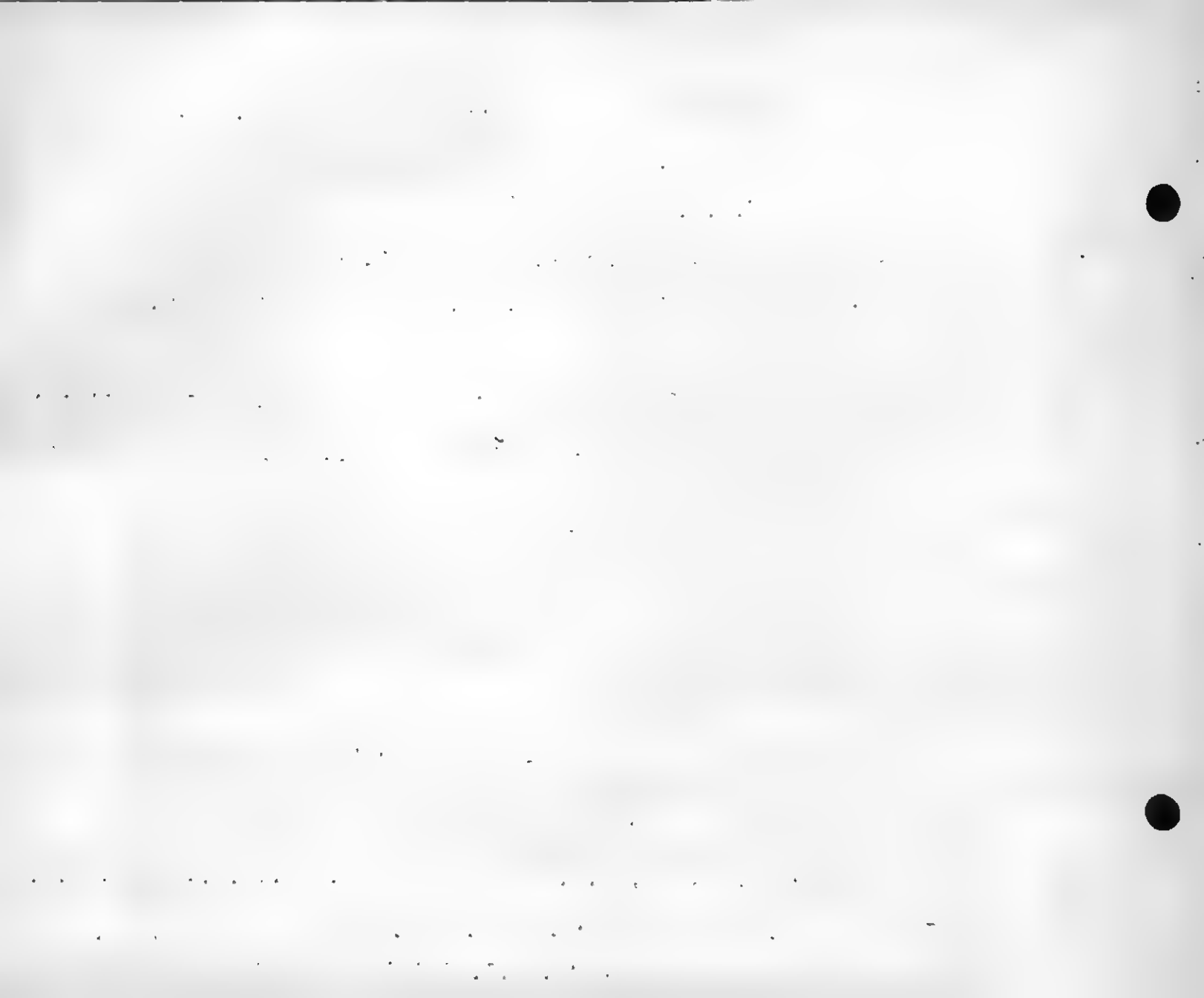
J. Kessler, MD

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last ISADORE GOLDBERG			2a. DATE OF DEATH Month Day Year JAN. 30, 1969		2b. HOUR 12 45 PM
3 SEX Male	4. RACE Caucasian		5 DATE OF BIRTH April 7, 1902		6. AGE (In years last birthday) 66 YRS.
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 904 De Vere Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Grocer	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery Sil. Spg.		13c. STREET AND NUMBER 904 De Vere Drive	
14. FATHER'S NAME First Middle Last Lazer Goldberg			15 MOTHER'S MAIDEN NAME First Middle Last Leah		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-18-3974		17. INFORMANT Address Theo. Litovitz - 904 De Vere Dr., S.S. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PARALYSIS AGITANS, ADVANCED 342X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 11-15 , 19 68 , to 1-19 , 19 69 , that (I) (we) lost saw the deceased alive on 1-19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Israel Kessler, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 1/30/69	
22d. PHYSICIAN'S NAME (Type) ISRAEL KESSLER, M.D.				22e. ADDRESS 5801 16th. St., N.W., Wash., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/31/69		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Falls Church, Va.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 3501 14th. St., N.W. Wash., D.C.		25a. REC'D BY REGISTRAR DATE FEB 4 1969	
				25b. REGISTRAR'S SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

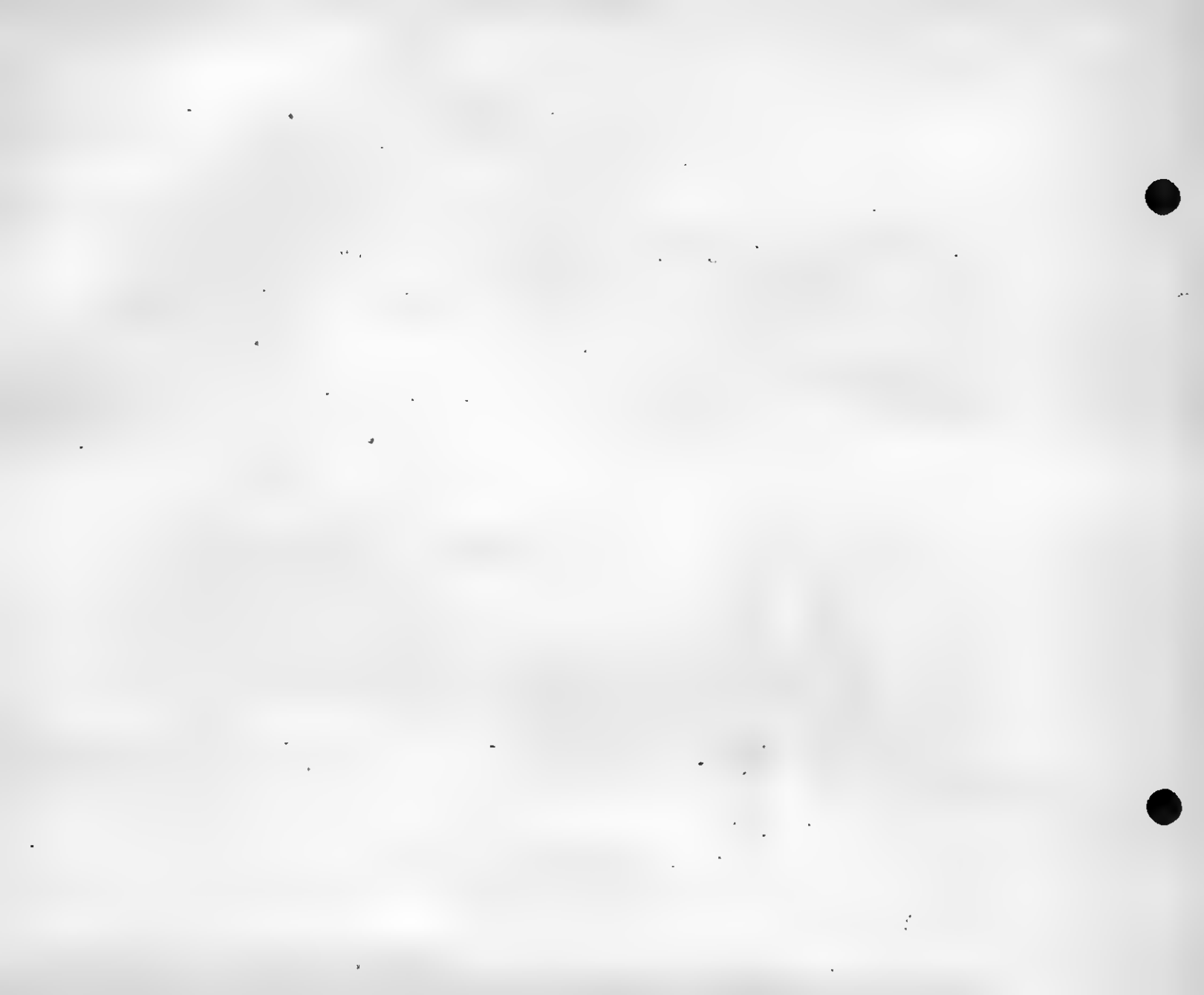
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

0109~

1087

1. DECEASED-NAME (Type or print) IDA			First	Middle	Last	2a. DATE OF DEATH Month JAN Day 13 Year 1969			2b. HOUR 5 30 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-15-96		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md				
10. CITY OR TOWN OF DEATH SILVER SPRING MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHEVY CHASE NURSING & CONVALESCENT HOUSE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9210 EWING DRIVE		
14. FATHER'S NAME First Middle Last KOSOFESKY			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 062-38-5568		17. INFORMANT Address Arthur Spindler 9210 Ewing Dr., Bethesda, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of ovary with metastases 18.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from Jan 9 , 19 68 , to Jan 13 , 19 69 , that (I) (we) last saw the deceased alive on Jan 9 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 13, 1969
22d. PHYSICIAN'S NAME (Type) BLAINE H. EIG		22e. ADDRESS 4801 Denia Ave, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-14-69		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery		23d. LOCATION (City or Town) Woodbridge, New Jersey		(County)		(State)
24. FUNERAL DIRECTOR Donald M. Stein				ADDRESS 232 Carroll St. NW, Wash. D.C.		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last EMMA R.W. GRAY			2a. DATE OF DEATH Month 1 Day 17 Year 69		2b. HOUR 2:40 AM
3. SEX Female	4 RACE White	5 DATE OF BIRTH June 21, 1886		6 AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San & Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk-U.S. Govt.	12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8101 14TH AVE. APT. 101	
14. FATHER'S NAME First Middle Last George A. GRAY	15. MOTHER'S MAIDEN NAME First Middle Last SARAH Sarah E. Peters Lamb				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO 217-46-5321	17. INFORMANT PATIENT'S chart Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/9/69</u> , 19 <u>69</u> , to <u>1/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas J. Fogarty</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>1/21/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Thomas J. Fogarty</u>		22e. ADDRESS <u>Proctor's Bldg E</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/20/69	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	23d. LOCATION (City or Town) (County) (State) Wash., D.C.		
24. FUNERAL DIRECTOR Home Inc.		ADDRESS Valley's Funeral Mt. Rainier, Maryland	25a. REC'D BY REGISTRAR JAN 21 1969	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>Offie M. Prime's</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>13</i> Year <i>69</i>			2b. HOUR <i>11:30</i> AM			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>3-20-1880</i>		6 AGE (in years last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M N	
7a BIRTHPLACE (State or foreign country) <i>WASHINGTON, D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S. AMERICA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery County</i> Md			
10 CITY OR TOWN OF DEATH <i>Pensacola</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Waring Home 3000 Inglewood Ave</i>		12a USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (where deceased lived, if institution before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4602 West Virginia Ave</i>	
14 FATHER'S NAME <i>WALTER JOHN E.</i>		15 MOTHER'S MAIDEN NAME <i>JULIA GIPSON</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO <i>UNKNOWN</i>		17 INFORMANT <i>WALTER F. GRIMES (SON)</i>		Address <i>4602 WEST VIRGINIA AVE. BETHESDA, MARYLAND</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renal failure</i>									
403 X DUE TO, OR AS A CONSEQUENCE OF (b) <i>Nephrosclerosis</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <i>Arteriosclerosis, generalized, hypertension 25 yrs.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>?CVA (12-27-68) Diabetes mellitus. Obesity</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <i>Prime, 1948</i> , to <i>Jan 13, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 12, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death									
22b SIGNATURE <i>Philip H. Varner</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>1-13-69</i>			
22d PHYSICIAN'S NAME (Type) <i>PHILIP H. VARNER M.D.</i>				22e ADDRESS <i>10620 GEORGIA AVE., SILVER SPRING, MD</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>JAN 17, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>CONGRESSIONAL CEMETERY</i>		23d LOCATION (City or Town) <i>WASHINGTON, D.C.</i>		(County) (State)	
24 FUNERAL DIRECTOR <i>W.W. CHAMBERS CO.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		25a REC'D BY REGISTRAR DATE <i>JAN 20 1969</i>		25b APPROXIMATE SIGNATURE <i>John J. Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 45M 1969

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) THOMAS OWEN GRIMES			2a. DATE OF DEATH Month JANUARY Day 22 Year 1969			2b. HOUR 10:45 A.M.	
3. SEX MALE		4. RACE white		5. DATE OF BIRTH JUNE 23, 1890		6. AGE (In years last birthday) 78 YRS	
7a. BIRTHPLACE (State or foreign country) Travilah Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bicche Greve Foundation, Olney, Md. 20832		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last James Owen Grimes		15. MOTHER'S M.A.D.E.N. NAME First Middle Last Elizabeth Henley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-165094	
17. INFORMANT Mr. Edward Grimes		18. ADDRESS 243 Montgomery Ave.		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INSUFFICIENCY, 1 HOUR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YES YES		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ORGANIC BRAIN SYNDROME: PYELONEPHRITIS: ANEMIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour 19 A.M. Month 10 Day 21 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from OCT 12, 1969 , to JAN 22, 1969 , that (I) (we) lost the deceased alive on JAN 21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald F. Lewis MD		22c. PHYSICIAN'S NAME (Type) DONALD F. LEWIS MD		22d. ADDRESS 700 CLOVERLY SILVER SPRING, MD		22e. DATE SIGNED 1/22/69	
23a. BURIAL CREMATION, BURIAL		23b. DATE 1/24/69		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City or Town) (County) (State) Gaithersburg Montg. Maryland	
24. FUNERAL DIRECTOR Tybon Wheeler F. H. 1331 Rockville Pike Rockville, Maryland				25a. RECD BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE William H. Cundiff	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH JOHN IRWIN GROVE, SR.													
1. DECEASED NAME (Type or Print) JOHN IRWIN GROVE, SR.			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year 1-28 1969			2b. HOUR 12:25				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-3-03		6. AGE (In years from birthday) 65 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Scotland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Takoma Park,				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. Gen. & Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD				13b. COUNTY XXXY P.C.				13c. CITY OR TOWN Tak. Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1207 Kirkburn Ave.	
14. FATHER'S NAME First Middle Last ALBERT GROVE				15. MOTHER'S MAIDEN NAME First Middle Last RACHEL									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO (If yes give war or dates of service) 577-30-1267				17. INFORMANT MRS. RACHEL Lou GROVE (Saman 132)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute suppurative pancreatitis</u> <u>5770</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN E. KEAPNO				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, town or county) JAN. 28, 1969				22b. DATE SIGNED					
23a. BURIAL CREMATION REMOVAL (Specify) Burial				23b. DATE Jan. 30, 1969		23c. NAME OF CEMETERY OR CREMATORY East Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Calmar Manor P. Co. Md.			
24. FUNERAL DIRECTOR Jardner Walters, Johns Funeral Home, 254 Carroll St. Wash. DC				25. REC'D BY REGISTRAR JAN 30 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Walter			H. Gruendl			MAY 31 1969			2:35 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR
M.	W.	Dec. 7 1912	56 YRS	1 MONTHS	24 DAYS	Jan 31 1969			3:00 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			MD
N.Y.		U.S.A.		Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USIA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Linden Hill Apartment Motel							
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5323 Pooks Hill Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS Bethesda, Md.		
Yes			054-16-300		Ann E. Gruendl		5323 Pooks Hill Rd.		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries - Severe -									Several.
DUE TO, OR AS A CONSEQUENCE OF (b) Trauma from Fall - from 8th floor									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		2:35 PM Jan 31 1969		Jumped from window of 8th floor.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No.		City or Town		County State	
		Motel		5400 Pooks Hill Rd.		Bethesda		Montgomery Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Jan 31, 1969	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
XXXXX		2-4-69		Arlington National		Arlington		Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						DATE Feb 6 1969		James J. Gage	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CLEARED - MEDICAL EXAMINER R. & R.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First GEORGE			Middle ALBERT		Last GUDE		Month 1 Day 12 Year 69		7:45 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-3-06		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired plumber		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 15306 Merrifields Drive			
14. FATHER'S NAME First Howard			Middle --		Last Gude		15. MOTHER'S MAIDEN NAME First Fannie		
Middle --			Last Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 2-9-03-1971		17. INFORMANT Fannie M. Gude Address Olney, Md.		17b. WHERE DECEASED Admission Rec'd., Montgomery Gen. Hospital,			
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Delirium Tremens</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic alcoholism</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Carcinoma of Sigmoid + Ascending Colon + Arteriosclerotic</u>									
19a. DATE OF OPERATION 1/9/69									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Colon									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS INCLUDED IN CERTIFYING CAUSES OF DEATH? Hypertensive disease									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 1/5, 1969, to 1/12, 1969, that (I) (we) last saw the deceased alive on 1/12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur F. Woodward, M.D.									
22c. DATE SIGNED 1/13/69									
22d. PHYSICIAN'S NAME (Type) Arthur F. Woodward, M.D.									
22e. ADDRESS Rockville - Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-1591060									
23b. DATE 1-15-69									
23c. NAME OF CEMETERY OR CREMATORY St. Vincent Cemetery									
23d. LOCATION (City or Town) (County) (State) Suitland Pk. Geos. Md.									
24. FUNERAL DIRECTOR Paul Smith, Inc. 8434 Georgia Avenue									
25a. REC'D BY REGISTRAR JAN 20 1969									
25b. REGISTRAR'S SIGNATURE [Signature]									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="text-align: center;">0109J</div> <div style="text-align: right;">1094</div> <div style="text-align: center;">CERTIFICATE OF DEATH</div>										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
CARL			A.		HAAS, Sr.	1 31 69			544A-M	
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
MALE	W		2-23-95			73 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PA		U.S.A				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			PAINTER (RET.)		SAME		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD			PRINCE GEORGE		HYATTS.		YES <input type="checkbox"/> NO <input type="checkbox"/>		804 COX AVE	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME				
CHARLES					HAAS	MELISSA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			579 09 5444A		THRS. MATTIE L. HAAS, 804 COX AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 4 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriolar nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Hemorrhagic gastritis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)		21f. LOCATION		City or Town		County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Street or R.F.D. No						
22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 1969, to <u>1/31</u> , 1969, that (I) (we) last saw the deceased alive on <u>1/30</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Henry R. Wolfe M.D.							1/31/1969			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		Feb. 3, 1969		Washington National		Baltimore		Pa. Dist. Md.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arthur Walters, 254 Carroll St NW Wash DC					DATE FEB 3 1969		Charles J. Jones			

01100

CERTIFICATE OF DEATH

01095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <i>James I. Hambleton</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>69</i>			2b. HOUR <i>9:40</i> M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1-1-95</i>		6. AGE (in years last birthday) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>3</i>	
7a. BIRTHPLACE (State or foreign country) <i>Chile</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Brookville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>RFD 1 Box 57</i>	
14. FATHER'S NAME First <i>James Chase</i> Middle <i>Hambleton</i> Last <i>Paulsen</i>				15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Paulsen</i> Last <i>Paulsen</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>Yes</i>		(If yes give war or dates of service) <i>WW I</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife</i> <i>Mabel N. Hambleton</i> Address <i>Same as Item 13.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Influenza</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pneumonia, Edema - Acute Subacute</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>1</i> Day <i>4</i> Year <i>69</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>1/4 69</i> City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md.</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/4/69</i> , 19 <i>69</i> to <i>1/4</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>1/4</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Barton J. Gershen</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/15/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>BARTON J. GERSHEN</i>				22e. ADDRESS <i>50 W. Edmonston Drive Rockville, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>1-8-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>1/10/69</i>		25b. REGISTRAR'S SIGNATURE <i>William A. Carter</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) Roy G. Hamlin						2a. DATE OF DEATH Month 1 Day 24 Year 69			2b. HOUR 4:30 M		
3 SEX Male		4. RACE White		5 DATE OF BIRTH 2-15-85		6 AGE (In years last birthday) 83 YRS.		7 UNDER 1 YEAR MONTHS 0 DAYS 0		7 UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) New Hampshire		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) suburban			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED OWNER			12b KIND OF BUSINESS OR INDUSTRY Insurance		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE New Hampshire				13b COUNTY Gorham		13c CITY OR TOWN Gorham		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last Charles G. Hamlin				15 MOTHER'S MAIDEN NAME First Middle Last Lydia Blake							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO 001-26-7437		17 INFORMANT John G. Hamlin (son)				Address 64 McIntire Rd. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infection - Urinary tract 5997 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) blood abstinence & infection DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus CVA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-26-1968 to 1-29-1969 , that (I) (we) last saw the deceased alive on 1-25-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death											
22b. SIGNATURE John S. Saia MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1-29-69		
22d. PHYSICIAN'S NAME (Type) John S. Saia						22e. ADDRESS 809 Viers Mill Rd MD					
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE Feb. 3, 1969			23c. NAME OF CEMETERY OR CREMATORY Evans Cemetery			23d. LOCATION (City or Town) (County) (State) Gorham, New Hampshire		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.			ADDRESS 8434 Georgia Ave., Silver Spring, Md.			25a. REC'D BY REG. STRAR FEB 3 1969			25b. REGISTRAR'S SIGNATURE John S. Saia		

01102

CERTIFICATE OF DEATH

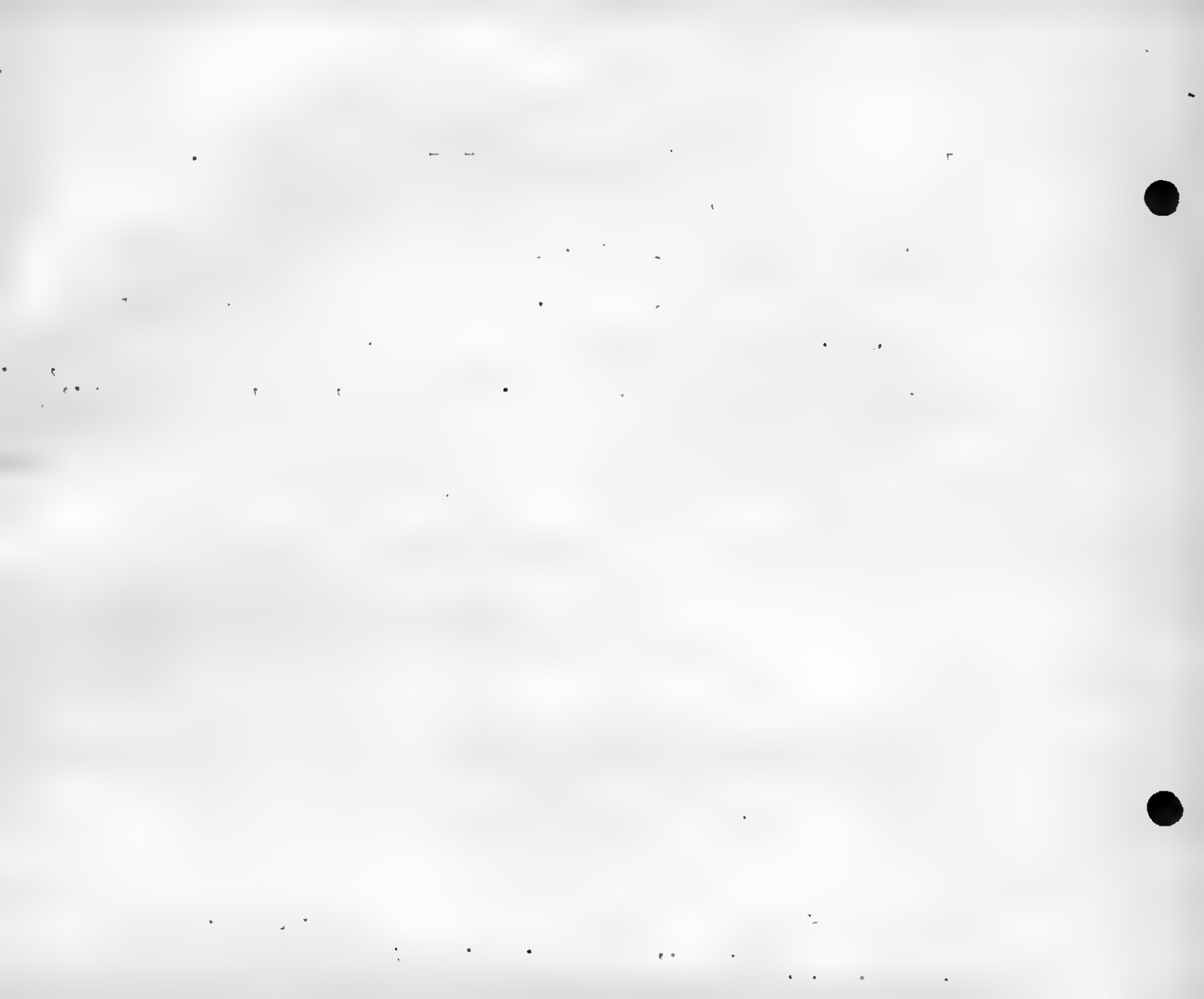
01037

1. DECEASED NAME (Type or print) <u>Elizabeth</u> First <u>Horton</u> Middle <u>Horton</u> Last			2a. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1969</u>			2b. HOUR <u>8:20</u> P M						
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>12-23-1876</u>		6. AGE (in years last birthday) <u>92 yrs.</u>		7. IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		8. IF UNDER 24 HRS HOURS <u>0</u> M. <u>0</u>		
7a. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md						
10. CITY OR TOWN OF DEATH <u>Kensington</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Carroll Hall Sanitarium</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>At home</u>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Chevy Chase</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5410 Grove Street</u>		
14. FATHER'S NAME First <u>Joseph</u> Middle <u>Horton</u> Last <u>Horton</u>				15. MOTHER'S MAIDEN NAME First <u>Frances</u> Middle <u>Anna</u> Last <u>Frederick</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Mrs. Rita Maroney, Niece, <u>5410 Grove St.,</u> Address <u>Chevy Chase, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Coronary Arteriosclerosis</u> (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1960</u> , to <u>Jan 9, 1969</u> , that (I) (we) last saw the deceased alive on <u>Nov 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Robert B. Havell MD</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>Jan 9, 1969</u>						
22d. PHYSICIAN'S NAME (Type) <u>Robert B. Havell MD</u>						22e. ADDRESS <u>5516 Nebraska Ave - DC</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1-10-1969</u>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) <u>Johnstown, Pennsylvania</u>				
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5250 Wisc. Ave. N.W., Wash., D.C., 20016</u>						25a. REGD BY REGISTRAR <u>JAN 13 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Medical Examiner notified



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) <i>Elizabeth P. Harold</i>			First Middle Last			2a. DATE OF DEATH Month <i>Jan</i> Day <i>20</i> Year <i>1969</i>		2b. HOUR <i>4 P</i> M		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>June 29 1895</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <i>Tairland</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>S.S.Md.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>815 Milestone Dr</i>	
14. FATHER'S NAME <i>August Plitt</i>			First Middle Last			15. MOTHER'S MAIDEN NAME First <i>Dorothy</i>			Middle Last <i>Margold</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> or (Unknown) <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Elsie H. Plitt</i>			Address <i>Sil. Spr., Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC HEART DIS.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>SENILITY</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>LEFT HEMIPLEGIA</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from <i>1-5-6</i> , 19 <i>66</i> , to <i>1-20</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-9-</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>Samuel A. Hillman</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1-20 69</i>		
22d. PHYSICIAN'S NAME (Type) <i>SAMUEL A. HILLMAN</i>						22e. ADDRESS <i>8829 FLOWER AVE SILVER SPRING, MD 20901</i>				
23a. BURIAL, CREMATION, or other disposition <i>Burial</i>			23b. DATE <i>1-23-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>		
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>						ADDRESS <i>Sil. Spr., Md.</i>		25. REC'D BY REGISTRAR <i>JAN 24 1969</i>		
26. FUNERAL HOME <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Registrar immediately prior to burial, cremation, or removal, and in any event within 72 hours after death.

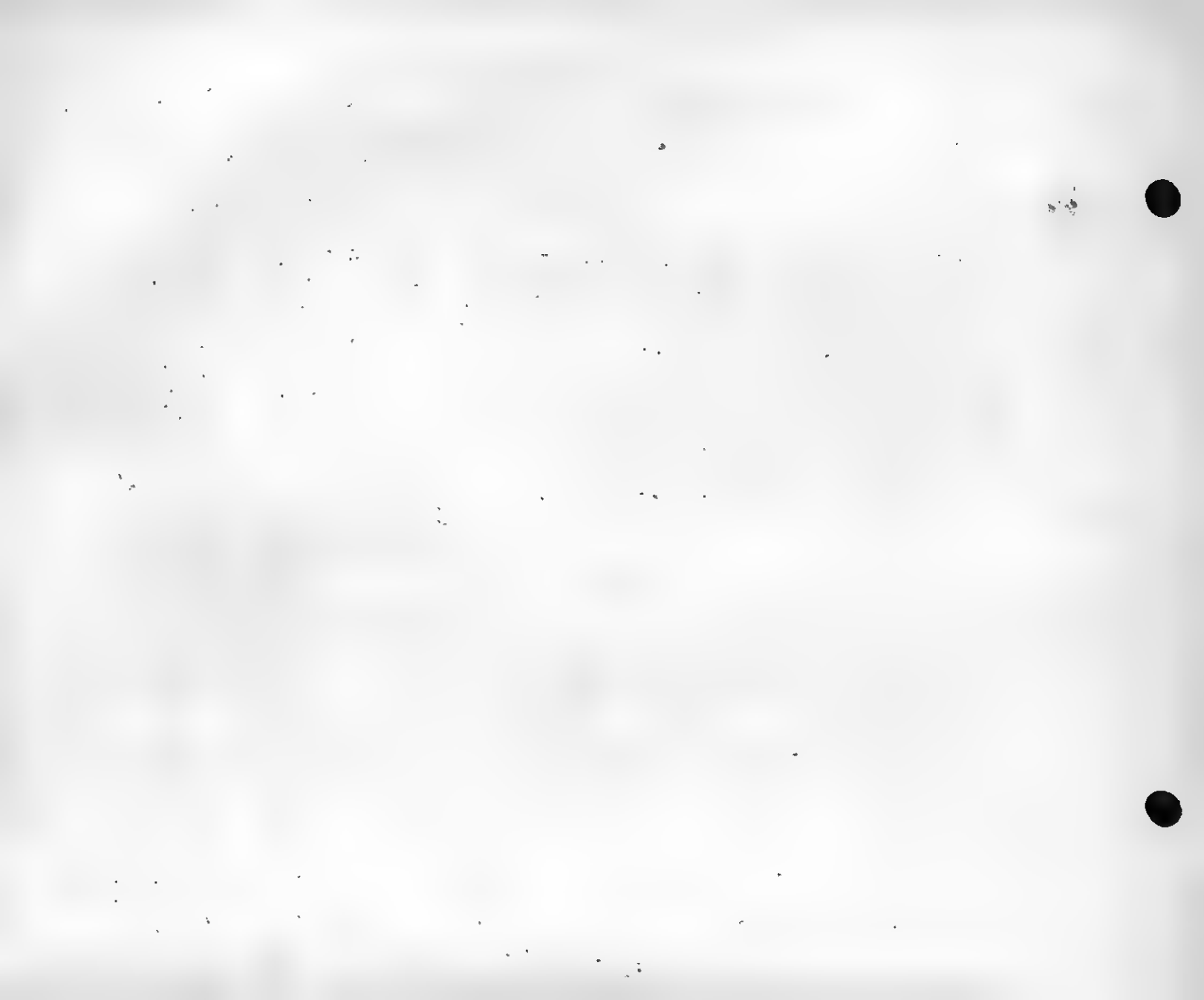
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Mary Woods Hansen						Month Day Year		Jan 23 1969		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 F UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
Female	White	9/10/91	77 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		2d HOUR		
Mass.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Jan 23 1969		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USJAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
Bethesda		Suburban Hospital		HOUSEWIFE		AT HOME				
13a USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Wash, DC					Wash DC		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6135 Utah Ave, N.W.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Robert McCune Woods			Anna Fairbank							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
N/A			579-48-8908		NIELS HANSEN - SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>								3 days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fracture of Rt Femur + Rt Humerus</u>								61 days		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Cardiovascular Disease</u>								years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Diabetes Mellitis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			2 P.M. Nov 17 1968		Fall at home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No.		City or Town		County State		
Home		Home		6135 Utah Ave		Washington, DC		DC		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Jan 23 1969				
Dr. John G. Ball			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) MONTG. CO. MD.				
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
1/25/69		CREMATION		CEDAR HILL CREMATORY		SUITLAND, MD.				
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
JOS. GAWLER'S SONS, 5130 WIS. AVE, WASH, D.C.				JAN 29 1969		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Katherine B. Hanson</i>			2a DATE OF DEATH <i>Jan.</i> Month <i>19</i> Day <i>19</i> Year <i>1969</i>			2b HOUR <i>6:45</i> P.M.				
3 SEX <i>Female</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>4/24/1901</i>		6 AGE (In years last birthday) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Holy Cross Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Insurance Agent</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>MD.</i>			13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>827 Bonifant St.</i>	
14. FATHER'S NAME First Middle Last <i>George -- Byron</i>			15 MOTHER & MAIDEN NAME First Middle Last <i>Rosina -- Schwab</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO. <i>577-10-9500R</i>		17. INFORMANT <i>James W. Wiegman</i>			Address <i>Riverdale, Md.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma in lungs & liver</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of right breast</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> <i>14 months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>1951</i> , 19____, to <i>Jan 19</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>Jan 19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Arnon H. Traum MD</i> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>January 20 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>Arnon H. Traum, M.D.</i>					22e ADDRESS <i>8237 Georgia Ave Silver Spring Md.</i>					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>1-23-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Northwood Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR <i>C. Glen Carter</i> ADDRESS <i>Sil. Spr. Md.</i>					25a. REC'D BY REGISTRAR DATE <i>JAN 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard J. [Signature]</i>			
24b. ADDRESS <i>8434 Georgia Avenue</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1 DECEASED-NAME (Type or print) <i>John L Harbaugh</i>					2a. DATE OF DEATH Month <i>Jan</i> Day <i>22</i> Year <i>1969</i>			2b. HOUR <i>9A</i> M	
3. SEX <i>Female</i>		4 RACE <i>W</i>		5. DATE OF BIRTH			6 AGE (In years lost birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>254 Twin Lakes St</i>	
14. FATHER'S NAME First <i>David</i> Middle <i>Rudolph</i> Last <i>Schussel</i>			15. MOTHER'S MAIDEN NAME First <i>Emma</i> Middle <i>Gotthardt</i> Last <i>Gotthardt</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>NO</i>			
16b. SOCIAL SECURITY NO <i>202-20-1781</i>			17. INFORMANT <i>Kenne C Muller (Daughter)</i> Address <i>Kenne C Muller</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>10 years</i> <i>10 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Obstructive Pulmonary Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/27/69</i> , to <i>1/22/69</i> , that (I) (we) last saw the deceased alive on <i>1/21/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert E. Macon M.D.</i>				22c. DATE SIGNED <i>1/22/69</i>		22d. PHYSICIAN'S NAME (Type) <i>254 Twin Lakes Pl, Rockville Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/24/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harbaugh's</i>		23d. LOCATION (City or Town) (County) (State) <i>Franklin Pa.</i>			
24. FUNERAL DIRECTOR <i>David Z. Grove,</i>		25a. REC'D BY REGISTRAR <i>JAN 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 4, 5, 6, 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Margaret Gresham HARDISON					2a. DATE OF DEATH January Month 23 Day 69 Year			2b. HOJR 557A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH July 3, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Virginia		13b. COUNTY Arlington		13c. CITY OR TOWN Arlington		3d. INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 505 South Garfield St.	
14. FATHER'S NAME First Middle Last John Walker Coffey			15. MOTHER'S M A DEN NAME First Middle Last Sallie -- McCollough						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) --		16b. SOCIAL SECURITY NO 572 34 6079		17. INFORMANT Arlington, Va.		Address Mrs. Sally H. Shaw, 4201 S. 31st St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIA INFRACTION 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Jan. 12 , 19 69 , to Jan. 23 , 19 69 , that (X) (we) last saw the deceased alive on Jan. 23 , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death									
22b. SIGNATURE <i>Joseph L. Kennedy</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED 23 Jan. 1969				
22d. PHYSICIAN'S NAME (Type) JOSEPH L. KENNEDY					22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-28-1969		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.			
24. FUNERAL DIRECTOR C. Glen Carter Warner & Sons ADDRESS Funeral Home 8434 Georgia Ave., Silver Spring, Maryland					25a. REC'D BY REGISTRAR JAN 29 1969		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 408 1-21-69										MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01103									
01108										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR				
Richard D. (No name)					Hargrove					1 Month 1 Day 69 Year					6:30 A.M.				
3. SEX		4. RACE			5. DATE OF BIRTH					6. AGE (In years lost birthday)					F UNDER 1 YEAR		F UNDER 24 HRS.		
Male		Caucasian			1/13/1893					75 YRS.					MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH										
Stillwater, Mo.			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery Md.										
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
Wheaton				University Nursing Home				Electrician											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
penna.					17b COUNTY					Newberry		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2227 West 4th Street					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
First Middle Last					First Middle Last														
Rufus					Hargrove					Mary Ellen					Copeland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address				
No					173-09-7700					University Nursing Home					Wheaton, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>485X</u> DUE TO, OR AS A CONSEQUENCE OF X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) <u>fractured hip</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 wks</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>V</u>					21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>67</u> , to <u>1/1/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/1/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Myron L. Linkin</u>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <u>1/1/69</u>				
22d. PHYSICIAN'S NAME (Type) Myron L. Linkin										22e. ADDRESS									
23a. BURIAL, CREMATION, OR OTHER DISPOSITION					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)				
Burial					1-4-69					Wildwood Cemetery					Williamsburg Lycoming Pa.				
24. FUNERAL DIRECTOR Robert A. Pumphrey										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
7557-Wisconsin, Ave., Bethesda, Md.										JAN 10 1969					<u>James J. J...</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First M. Middle Middle Last			2a. DATE OF DEATH Month 1 Day 12 Year 1969			2b. HOUR 8:35 PM
NELLIE STAGE HARLAN									
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 9/5/1892		6. AGE (In years last birthday) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Univ. Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIM. 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7101 Wildrose Drive	
14. FATHER'S NAME First Middle Last Hugh A. Morrison			15. MOTHER'S MAIDEN NAME First Middle Last Clara Leech						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO 577-07-2005		17. INFORMANT Mrs. Dan Rice 14720 Antioch Avenue		Address Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cause of Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11</u> , 1969, to <u>Jan 12</u> , 1969, that (I) (we) lost the deceased alive on <u>Jan 11</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (ad) (did not) view the body after death.									
22b. SIGNATURE <u>Blaine Eig</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/12/1969			
22d. PHYSICIAN'S NAME (Type) Blaine Eig, M.D.		22e. ADDRESS 8641 Colesville Rd., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-15-1969		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pk. Georges, Md.			
24. FUNERAL DIRECTOR Harold E. Pophreu, Jr. 8434 Georgia Avenue		25a. REC'D BY REGISTRAR JAN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

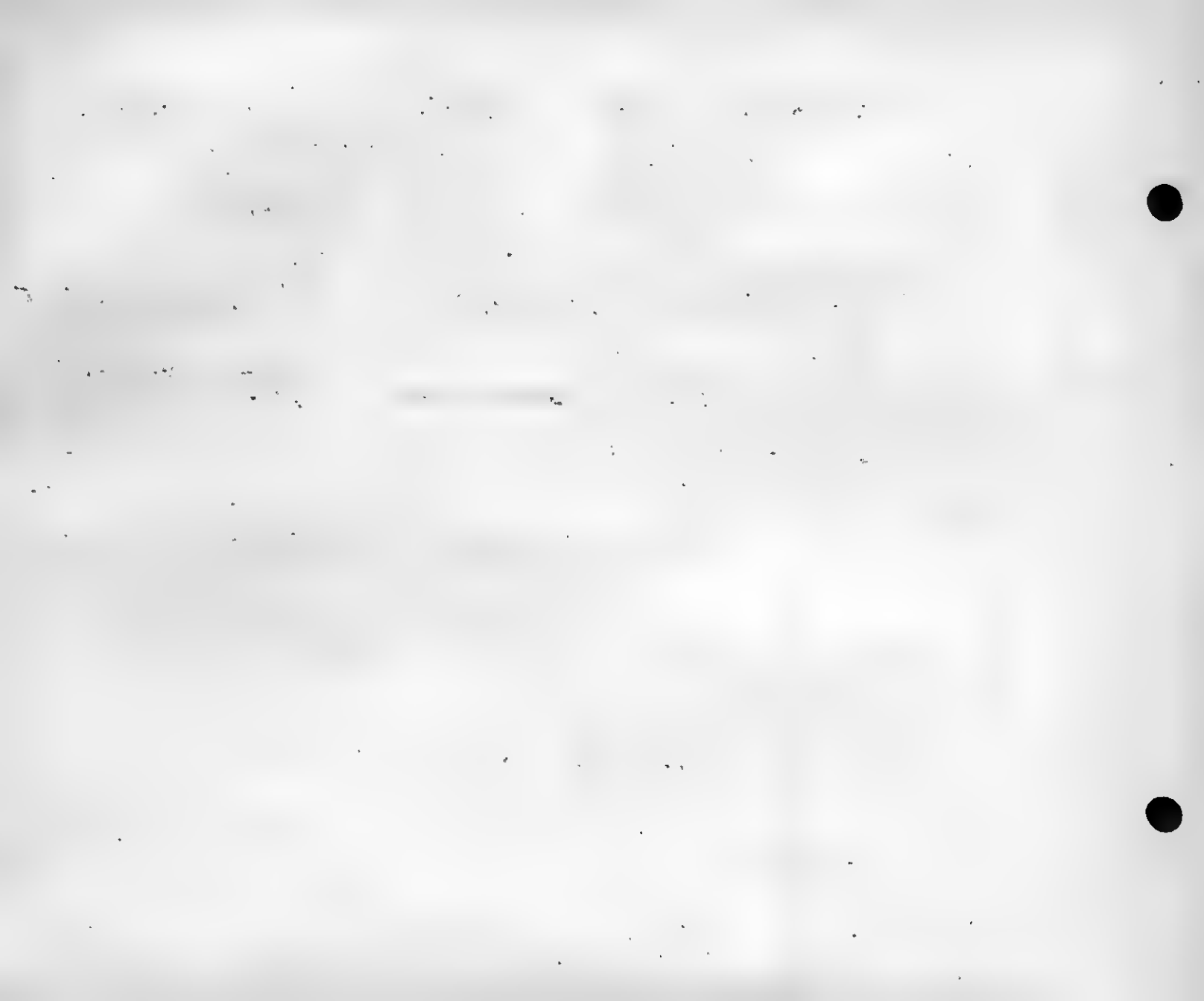
1 DECEASED NAME (Type or Print) Roland		First Roland		Middle Harrison		Last Harrison		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-27-69 MONTH DAY YEAR		2b HOUR M	
3 SEX M	4 RACE W	5. DATE OF BIRTH Jan 19, 1934		6. AGE (In years last birthday) 35 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 1-28 Day Year 1969 2d HOUR 1:15 P.M.	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7123 Sycamore Ave				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pressman		12b KIND OF BUSINESS OR INDUSTRY Merkle Press Co			
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE D		13b COUNTY Montgomery		13c CITY OR TOWN Takoma Park		13d INSIDE CITY, M 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7123 Sycamore Ave			
14. FATHER'S NAME First Middle Last Phillip R Harrison				15 MOTHER'S MAIDEN NAME First Middle Last Clara Chipman							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) yes				16b SOCIAL SECURITY NO. Korean		17. INFORMANT Patricia A Harrison		ADDRESS Hyattsville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis of liver, advanced DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Keap		EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED JAN. 28, 1969	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Jan 31, 1969		23c NAME OF CEMETERY OR CREMATORIUM Baltimore National		23d LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR F. Ga sch's Sons				ADDRESS Hyattsville, Md.		25a RECEIVED BY REGISTRAR FEB 3 1969		DATE		25b REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) RAYMOND First NMN Middle HAZEL Last			2a. DATE OF DEATH 1-19-1969 Month 1 Day 19 Year 1969		2b. HOUR 7 M A
3. SEX MALE		4. RACE CAUCASIAN	5. DATE OF BIRTH 5-21-1871		6. AGE (In years last birthday) 97 YRS.
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH MONTGOMERY			Md		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5412 KIRKWOOD DRIVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND		13b. CITY OR TOWN BETHESDA		13c. INSIDE CITY & HT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First HENRY Middle HAZEL Last LOUISE		15. MOTHER'S MAIDEN NAME First LOUISE Middle BOWEN Last BOWEN		ADDRESS 513	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-60-6110		17. INFORMANT MRS. MYRL L. FARRELL, DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Heart failure					1 day
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction					1 day
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction					1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960 , to Jan 10, 1961 , that (I) (we) last saw the deceased alive on Jan 10, 1961 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles E. Woodson		DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-22-1969	
22d. PHYSICIAN'S NAME (Type) CHARLES E. WOODSON		22e. ADDRESS 5130 WISCONSIN AVE. N.W. WASH. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-22-1969		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
23d. LOCATION (City or Town) WASHINGTON, D.C.		(County)		(State)	
24. FUNERAL DIRECTOR JOSEPH GAULERS		ADDRESS 5130 WISCONSIN AVE. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR JAN 24 1969	
25b. REGISTRAR'S SIGNATURE James Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1544
304 RE 1/68

01112

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01108

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) JOSEPHINE ELECTA HEAD			2a. DATE OF DEATH Month JAN Day 9 Year 1969			2b. HOUR 6 A M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH November 7, 1878		6 AGE (In years lost birthday) 90 YRS.	
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8714 Cameron Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8714 Cameron Street, Apt. 207		14. FATHER'S NAME First Smith Middle Lucetta Last Hudson		15. MOTHER'S MAIDEN NAME First Lucetta Middle Hudson Last Hudson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO	
16b. SOCIAL SECURITY NO		17. INFORMANT Curtis L. Head		17. ADDRESS 8714 Cameron Street Silver Spring Md 20910		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4123 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from Aug. 1959 , to Jan 7, 1969 , that (1) (we) last saw the deceased alive on 1969 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James R. Coleman MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 9, 1969	
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		22e. ADDRESS 9241 COLUMBIA BLVD		22f. CITY OR TOWN SILVER SPRING		22g. STATE MD.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE January 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Switzland Prince Geo Md	
24. FUNERAL DIRECTOR Arthur Walters		24a. ADDRESS 254 Carroll St. N.W.		24b. CITY OR TOWN Washington, D.C.		24c. STATE D.C.	
25a. RECD BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE JAN 13 1969		25d. REGISTRAR'S SIGNATURE [Signature]	

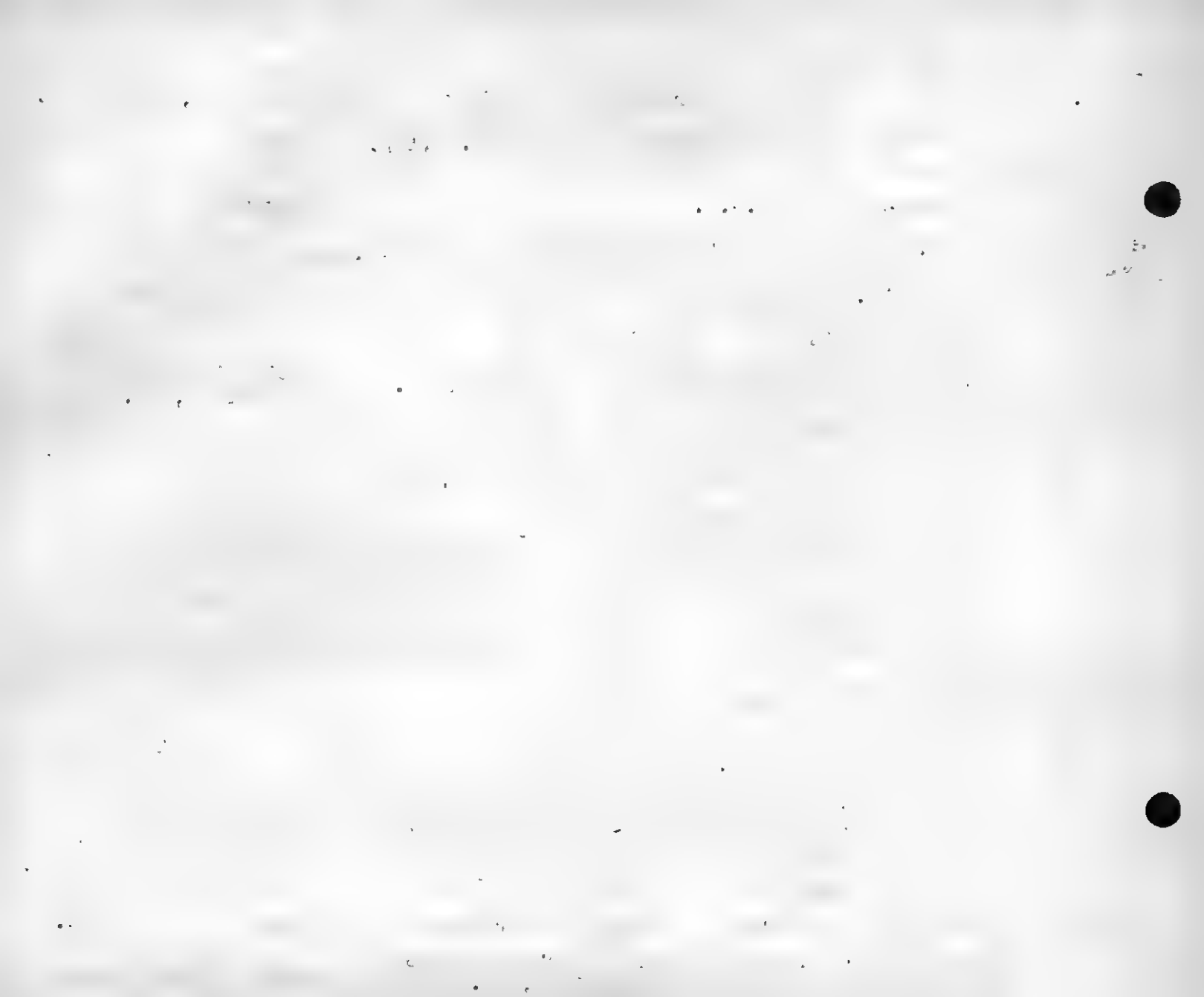
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, orders, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Ella Frances Helmlinge			2a. DATE OF DEATH Month January Day 30 Year 1969			2b. HOUR 5:58 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 8, 1873		6. AGE (In years at birthday) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9201 Burley Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9201 Burley Drive	
14. FATHER'S NAME First Louis Middle Last Nippert			15. MOTHER'S MAIDEN NAME First Ida Middle Last Von Uxkull						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Elisabeth H. Smith		6018 Tilden Lane Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 4123 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROSIS AND DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS GRADUAL 10 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN , 1949, to JAN , 1969, that (I) (we) last saw the deceased alive on JAN 27 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR. LEO I. DONOVAN				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/30/69			
22d. PHYSICIAN'S NAME (Type) DR. LEO I. DONOVAN				22e. ADDRESS 8214 WISCONSIN AVE BETHESDA MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 2/1/1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Md.			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rockville Pike		25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	
				Rockville, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last <i>Jane E. Hemstock</i>						2a. DATE OF DEATH Month Day Year <i>1 25 69</i>		2b. HOUR <i>12 35 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>5-3-90</i>		6 AGE (In years last birthday) <i>78</i>		7 UNDER 1 YEAR MONTHS DAYS <i>8 22</i>		8 UNDER 24 HRS HOURS MIN <i></i>	
7a BIRTHPLACE (State or foreign country) <i>England</i>		7b CITIZEN OF WHAT COUNTRY? <i>Canada</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a USUAL OCCUPATION (Kind of work done during most of working, i.e. even retired) <i>HOUSEWIFE</i>		12b KIND OF BUSINESS OR INDUSTRY <i></i>	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md.</i>				13b COUNTY <i>Mont. Bethesda</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>8521 Thornden Terrace</i>	
14 FATHER'S NAME First Middle Last <i>Wright</i>				15 MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>NO</i>				16b SOCIAL SECURITY NO <i>NONE</i>		17 INFORMANT <i>MR. HYMAN SHENKER</i> Address <i>8521 THORNDEN TERR, BETHESDA MD</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolization</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart disease with</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>atrial fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>112</i>										APPROX MATH INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>undetermined</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>multiple abdominal surgery in the past</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1/1/20</i> , 19 <i>69</i> , to <i>1/25/1969</i> , that (I) (we) lost saw the deceased alive on <i>1/25/1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death											
22b SIGNATURE <i>Faruk Ozer</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>1/25/69</i>					
22d PHYSICIAN'S NAME (Type) <i>FARUK OZER</i>				22e ADDRESS <i>1125 Rockville Pike Rockville, Md.</i>							
23a BURIAL CREMATION <i>CREMATION</i> (Specify)		23b DATE <i>1-29-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Anglican Church Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Jordan Ontario Canada</i>					
24 FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>						25a REC'D BY REGISTRAR <i>JAN 29 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
7557-Wisconsin Ave., Bethesda, Md.											



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VR 1/68
304M RIV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Esther Cybella Hendrick</i>			2a. DATE OF DEATH 1 Month 10 Day 6 Year			2b. HOUR 10:30 PM	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>1/28/95</i>		6. AGE (In years last birthday) <i>73</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Penna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>America</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San. & Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY/AM ISO YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>209 Lincoln Ave.</i>		14. FATHER'S NAME First <i>Hugh</i> Middle <i>Milton</i> Last <i>Ada</i>		15. MOTHER'S MAIDEN NAME First <i>MERRIMAN</i> Middle <i></i> Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <i>578-05-7864-1</i>		17. INFORMANT <i>Washington San. & Hosp.</i>		Address <i>Takoma Park Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary atherosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pneumonia, diabetes, hypertension, or</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>January 3, 1969</i> , to <i>January 10, 1969</i> , that (I) (we) last saw the deceased alive on <i>January 10, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard H. Bendkamp</i>				22c. DATE SIGNED <i>1/11/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Bernard H. Bendkamp</i>	
22e. ADDRESS <i>10820 Davis Wheaton Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Jan 13, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Md</i>	
24. FUNERAL DIRECTOR <i>William H. Walters</i>				25a. REC'D BY REGISTRAR <i>JAN 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	

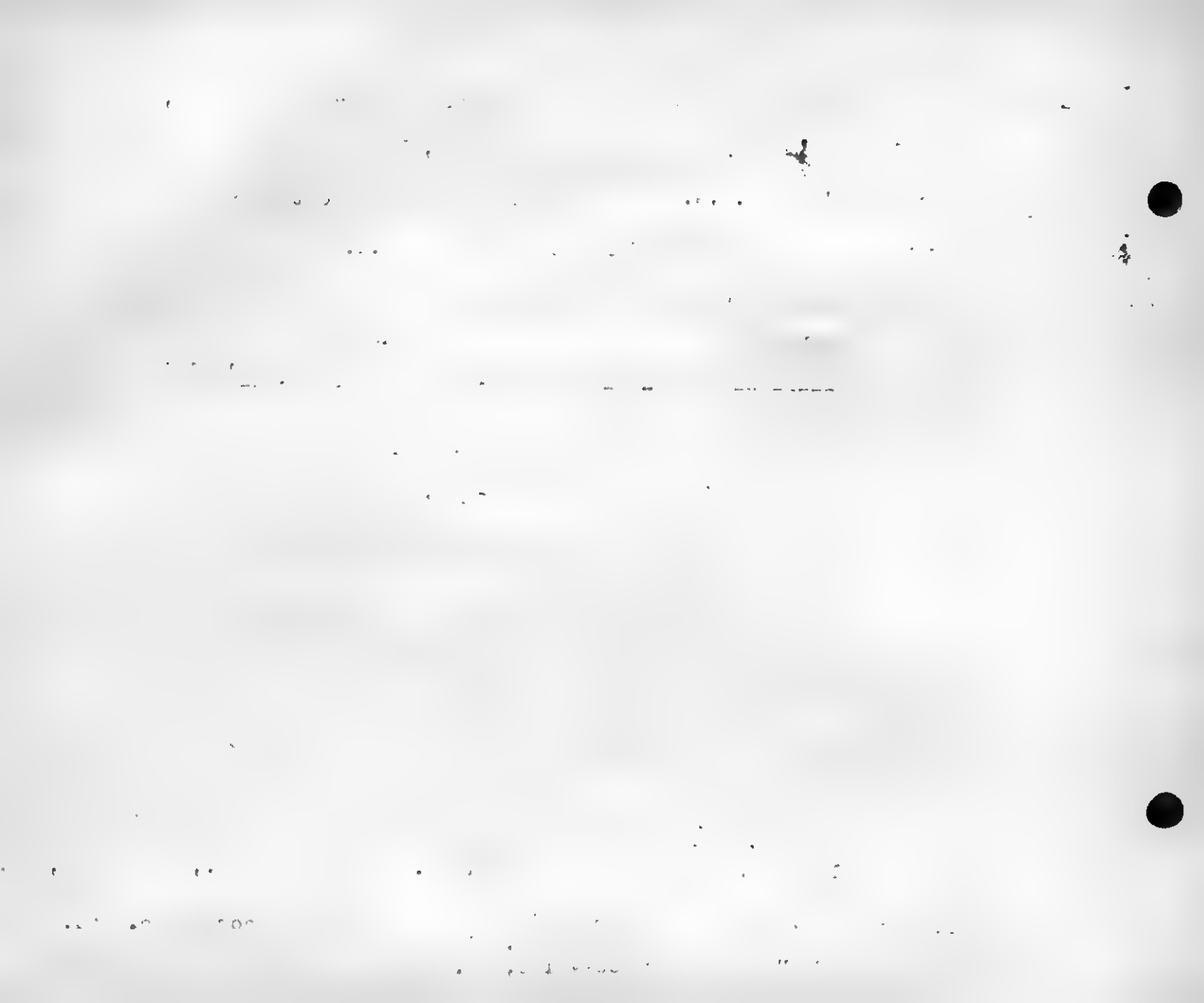


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VR 415
304 REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Bertha			Middle M/			Last Hendricks			2a. DATE OF DEATH Month January Day 7 , Year 69		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 24, 1892				6. AGE (In years by birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.									
10. CITY OR TOWN OF DEATH Germantown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Marylander Rest Home			12a. USUAL OCCUPATION (Kind of work done during normal working life, even if retired) N.E. A			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First Unknown Middle _____ Last _____			15. MOTHER'S MAIDEN NAME First Unknown Middle _____ Last _____			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) _____						16b. SOCIAL SECURITY NO. 578-44-5845		17. INFORMANT Washington, D.C. 20016 Bertha Cornell-Friend-4917 Redford Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 41a.1 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks 10 yrs. 20 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____									
22a. I certify that (I) (this hospital) attended the deceased from 7-3, 1965 , to 1-8, 1969 , that (I) (we) lost saw the deceased alive on 12-17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE W. F. Hall			22c. DATE SIGNED 1-8-69			22d. PHYSICIAN'S NAME (Type) William G. Hall									
22e. ADDRESS 615 W. Montgomery Ave., Rockville, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 1/8/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City or Town) (County) (State) Prince George Co. Md.							
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.			25a. REC'D BY REGISTRAR JAN 14 1969			25b. REGISTRAR'S SIGNATURE Charles Judge									



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01113

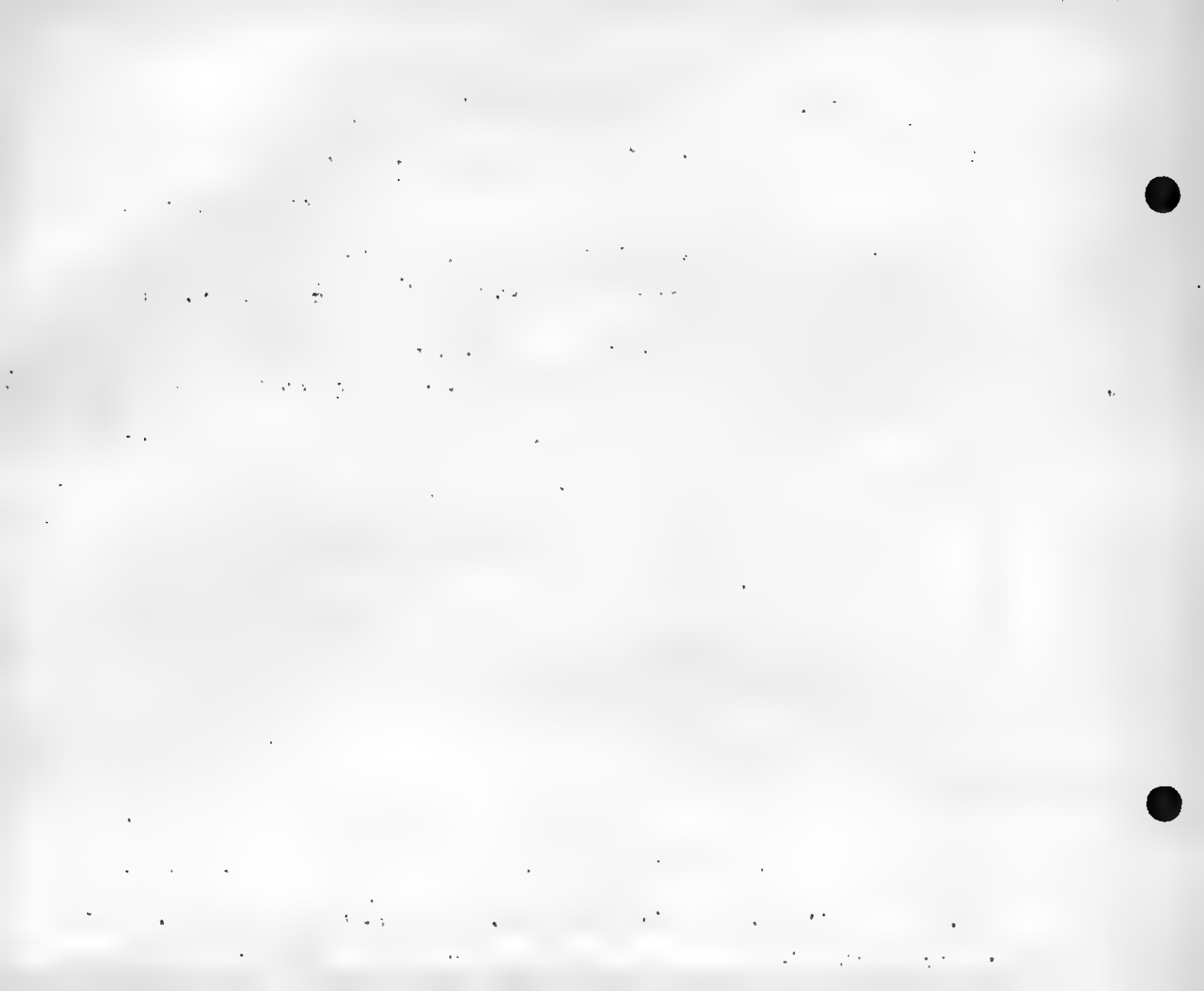
1 DECEASED-NAME (Type or print) Verlecia Vontrice HILLSMAN			2a. DATE OF DEATH Jan Month 13 Day Year 69			2b. HO JR 230A M					
3 SEX Female		4. RACE Negro		5 DATE OF BIRTH Jul. 3, 1968		6 AGE (in years last birthday) YRS		IF UNDER 1 YEAR MONTHS 6 DAYS		IF UNDER 24 HRS HOURS 00 MIN	
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Florida			13b. COUNTY DuVal		13c. CITY OR TOWN Jacksonville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 6805 Homer Rd., East		
14 FATHER'S NAME First Eddie Middle HILLSMAN Last			15. MOTHER'S MAIDEN NAME First Ethel Middle M Last ADAMS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown N/A (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Jacksonville, Fla. S/SGT Eddie HILLSMAN, USAF, 6805 Homer Rd. E.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Glycogen storage disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Hot while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that it (this hospital) attended the deceased from January 9, 1969 , to Jan. 13, 1969 , that it (we) last saw the deceased alive on Jan. 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. it (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John R. Howe M.D.</i> DEGREE John R. Howe, M.D.					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 13, 1969				
22d. PHYSICIAN'S NAME (Type) John R. Howe, M.D.					22e. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 1-17-69		23c. NAME OF CEMETERY OR CREMATORY Mount Olive		23d. LOCATION (City or Town) (County) (State) Jacksonville DuVal Fla.					
24. FUNERAL DIRECTOR John T. Rhines Co. ADDRESS 3015 12th St., N. E. Washington, D. C.					25a. REC'D BY REGISTRAR JAN-17 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last RAE HIRSHKOPF			2a DATE OF DEATH Month Day Year JAN 6 1969			2b HOUR 9:04 A M			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH SEPT. 15, 1893		6 AGE (in years last birthday) 75 YRS		7 UNDER 1 YEAR MONTHS DAYS 1 4 1	
7a BIRTHPLACE (State or foreign country) POLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md			
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b KIND OF BUSINESS OR INDUSTRY —			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6236 Clearwood Rd.	
14. FATHER'S NAME First Middle Last MAURICE Tannenbaum			15 MOTHER'S MAIDEN NAME First Middle Last REBECCA ROSENZWEIG						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Mrs. Estelle Palman - 6236 Clearwood Rd, Bethesda, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 YEAR	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from APRIL, 1957 , to 1-4, 1969 , that (I) (we) last saw the deceased alive on 1-2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Lester S. Blumenthal		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1-4 69			
22d. PHYSICIAN'S NAME (Type) Lester S. Blumenthal, M.D.		22e ADDRESS 5315 Connecticut Ave., N. W.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN. 5, 1969		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION (City or Town) (County) (State) FALLS CHURCH, VA.			
24 FUNERAL DIRECTOR BERNARD DANZANSKY & Sons - 3501-14th Street N.W.		ADDRESS Washington, D.C.		25a REC'D BY REGISTRAR JAN 8 1969		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONT.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> <input checked="" type="checkbox"/> COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL HALL Nursing Home</u>		d. STREET ADDRESS <u>1930 Columbia Rd. N.W.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>PAULINE B. HOBBS</u>		4 DATE OF DEATH Month Day Year <u>JAN 27 1969</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-6-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESEARCH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. STATE DEP.</u>	9. AGE (In years last birthday) <u>72</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILLARD F. HOBBS</u>		14. MOTHER'S MARDEN NAME <u>NANCY COLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>578-52-6031</u>	
17. INFORMANT <u>JOHN GUERHAT (Nephew)</u>		Address <u>KENSINGTON Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>4123</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>6 MOS.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>65</u> , to <u>1/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/26</u> , 19 <u>67</u> , and that death occurred at <u>11:44</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence Thomas M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-27-69</u>
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE THOMAS M.D.</u>		22d. ADDRESS <u>1712 EYE ST. N.W. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-30-69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>
24. FUNERAL DIRECTOR <u>John F. DeVol</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 2 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>William C. Under</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01120									
01116									
1. DECEASED NAME (Type or print) <u>Sandra L</u>			First <u>L</u> Middle <u>Hobbs</u> Last <u>Hobbs</u>			2a. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1969</u>		2b. HOUR <u>2:45</u> AM	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>6/30/17</u>		6. AGE (In years last birthday) <u>11</u> YRS		IF UNDER 1 YEAR MONTHS <u>11</u> DAYS <u>11</u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Student</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>--</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Clarksville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Halls Shop Road</u>	
14. FATHER'S NAME <u>Wilson</u>			First <u>L</u> Middle <u>Hobbs</u> Last <u>Hobbs</u>			15. MOTHER'S MAIDEN NAME <u>Doine</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO <u>--</u>			17. INFORMANT <u>Wilson L Hobbs</u>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatocellular degeneration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>--</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>11</u> Month <u>1</u> Day <u>11</u> Year <u>1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>NO</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. <u>1-11</u> City or Town <u>Bethesda</u> County <u>Montgomery</u> State <u>Md.</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV</u> , 19 <u>68</u> , to <u>1-11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-11</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jerry R. Shapner</u>					DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1-11-69</u>
22d. PHYSICIAN'S NAME (Type) <u>Jerry R. Shapner, M.D.</u>					22e. ADDRESS <u>8718 Wisconsin Avenue, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1-14-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Highland, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 20 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Dora None Hofberg			2a. DATE OF DEATH Month January Day 30 Year 1969			2b. HOUR 6:30 AM M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4- -90		6. AGE (In years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Rumania		7b. CITIZEN OF WHAT COUNTRY? Rumania		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Washington D.C.			13b. COUNTY —		13c. CITY OR TOWN —		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 815 Juniper Street		
14. FATHER'S NAME First ? Middle ? Last Margolis			15. MOTHER'S MAIDEN NAME First ? Middle ? Last ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO Unknown		17. INFORMANT Patient's chart Address ?						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension + Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. — Month — Day — Year 19 P.M. —		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No — City or Town — County — State —							
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 51 , to 1/30 , 19 69 , that (I) (we) last saw the deceased alive on 1/1/69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Benjamin Isaacson M.D. DEGREE — ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 1/30/69						
22a. PHYSICIAN'S NAME (Type) BENJAMIN ISAACSON, M.D.					22e. ADDRESS 7733 ALASKA AVE NW WASH. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-31-69		23c. NAME OF CEMETERY OR CREMATORY Ohev Shalom-Talmud Torah Cem			23d. LOCATION (City or Town) (County) (State) Wash. D.C.				
24. FUNERAL DIRECTOR Goldberg Funeral Home - 4217 9th Street N.W.					25a. REC'D BY REGISTRAR FEB 4 1969		25b. REGISTRAR'S SIGNATURE William J. Judge				

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>0112</div> <div>Item 13 Film 408 1/23/69 kk</div> </div> <div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>1118</div> </div>									
1. DECEASED-NAME (Type or print) First Middle Last MAY DARNELL HOLLINSHEAD					2a. DATE OF DEATH Month Day Year JANUARY 10 69			2b. HOUR 6:20 AM	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH 31 AUG 1874		6. AGE (In years last birthday) YRS 94		7. UNDER 1 YEAR MONTHS 8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT.			
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL HALL 10231 CARROLL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD. D.C.		13b. COUNTY MONT.		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3529 Quebec 10231 CARROLL	
14. FATHER'S NAME First Middle Last AARON DARNELL			15. MOTHER'S MAIDEN NAME First Middle Last SULSAN SHARP						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. -		17. INFORMANT Address SON- EARL D. HOLLINSHEAD BETHEL PARK, PA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOCLEROTIC HEART DISEASE 4127 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC MYOCARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) GENERALIZED ARTERIOCLEROSIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SENILITY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MAY 9, 1966 , to JAN. 10, 1969 , that (I) (we) last saw the deceased alive on JAN. 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Monica E. DeVol DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-10-69		
22d. PHYSICIAN'S NAME (Type) Monica E. DeVol					22e. ADDRESS 5206 NORWAY DR. CHEVY CHASE, MD.				
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE 1-11-69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or Town) (County) (State) SUITLAND MD.			
24. FUNERAL DIRECTOR Monica E. DeVol ADDRESS 2222 Wood Ave, N.W. D.C.					25a. REC'D BY REGISTRAR Jan 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MONTGOMERY COUNTY, MARYLAND, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
Howard Lawrence Holston						1-29-69			4:25 P		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		8-19-33		35 YRS.		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
Olney				Montgomery General Hospital				Cab driver			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Montgomery		Gaithersburg		Box 41			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME					
First Middle Last						First Middle Last					
Estell Holston						Stella Musser					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)						16b SOCIAL SECURITY NO.					
Unknown						Medical Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic and acute congestive heart failure										1 wk.	
Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomegaly (1060 gms) etio?										3 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral infarct due to embolus (1-25-69), Obesity, cholelithiasis											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION							
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		OFFICE BUILDING, ETC		Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-25-69, to 1-29-69, that (I) (we) last saw the deceased alive on 1-29-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Frederick Moomau, M.D.						1-30-69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Frederick Moomau, M.D. Sandy Spring Medical Center, Sandy Spring, Md.											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		Feb. 2, 1969		Laytonsville Cemetery		Laytonsville, Mont., Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis H. Barber Laytonsville, Md.						FEB 2 1969		R. L. Anderson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
01120													
Item # 03D, Film 2109 1/22/69													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Roy			J.			HONEYWELL			January Month Day 16 Year 69 730P M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		
Male		Caucasian		June 10, 1886			82 YRS		MONTHS		DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
New York			USA						Montgomery			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda			Naval Hospital			U.S. Army Chaplain							
13a. USLA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS DE CITY, MISS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Montgomery			Bethesda						4422 Rosedale Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
William Harrison			HONEYWELL			Sarah			ROGERS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
Yes			578-44-2689			Kensington			Mds.			Mrs. Julia H. Wright, 4913 Flanders Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA SECONDARY TO													
DUE TO, OR AS A CONSEQUENCE OF													
(b) MYOCARDIAL INFARCTION													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 5, 1968, to Jan 16, 1969, that (I) (we) last saw the deceased alive on Jan 16, 1969, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.													
22b. SIGNATURE													
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>													
22c. DATE SIGNED 17 Jan. 1969													
22d. PHYSICIAN'S NAME (Type) D. W. STEA, LCDR MC USN						22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Jan. 21, 1969			Arlington National			Arlington Arlington Va.				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home						25a. REC'D BY REG. SEAL			25b. REGISTERED SIGNATURE				
7557 Wisconsin Ave., Bethesda, Maryland						JAN 23 1969							

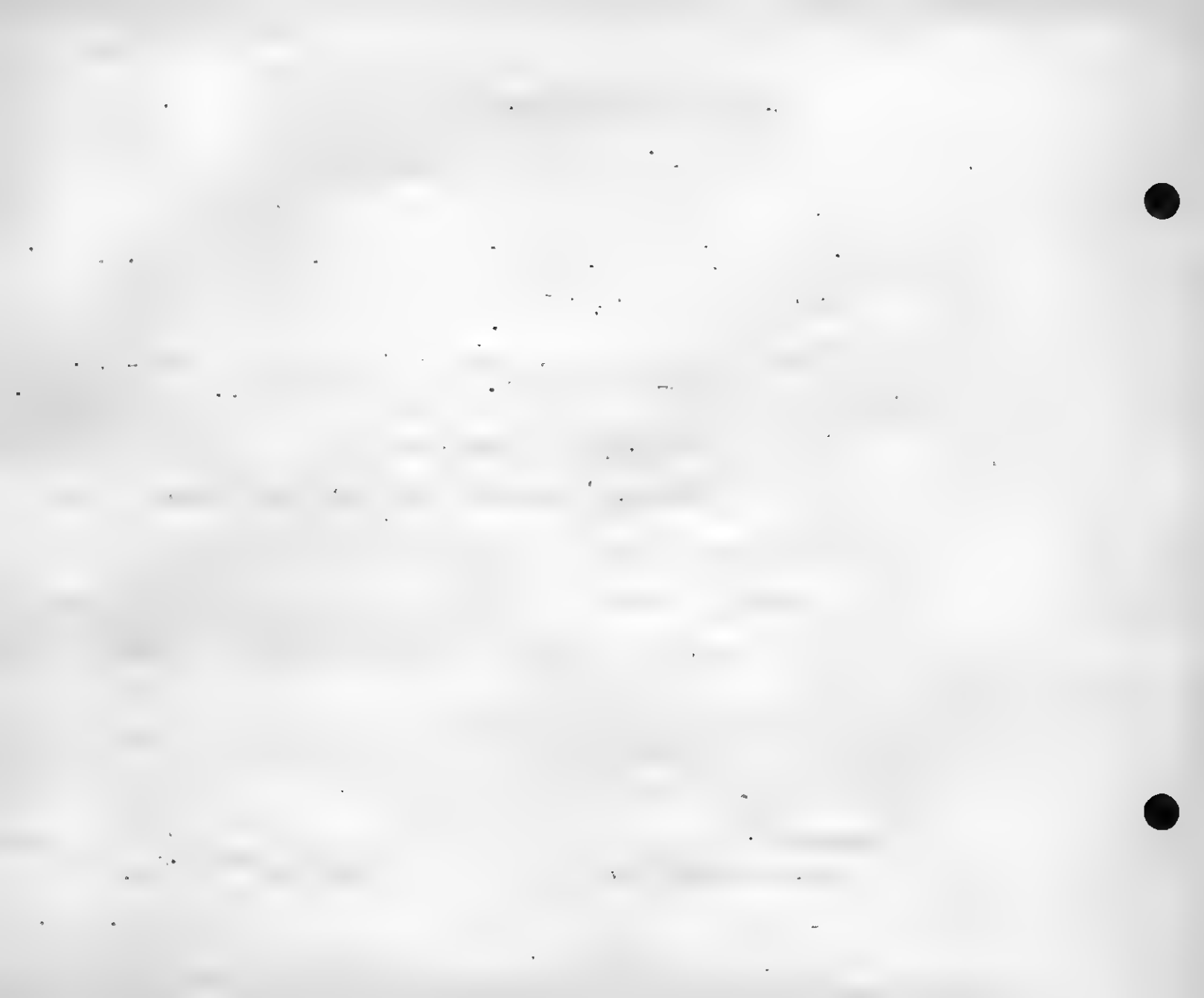
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (Rev. 3-58)
30M REV. 1-59

MEDICAL CERTIFICATION

31120		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01121	
1. DECEASED-NAME (Type or print) <u>Fletcher</u> First <u>S. HUBBARD</u> Middle <u>S.</u> Last				2a. DATE OF DEATH <u>1</u> Month <u>7</u> Day <u>69</u> Year		2b. HOUR <u>11P</u> M	
3. SEX <u>Male</u>		4. RACE <u>CAUC.</u>		5. DATE OF BIRTH <u>SEPT. 18, 1905</u>		6. AGE (In years last birthday) <u>63</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md	
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>8210-CUSTER Rd.</u>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <u>Lawyer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>BETHESDA</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>JOSEPH</u> Middle <u>Stiles</u> Last <u>Hubbard</u>		15. MOTHER'S MAIDEN NAME First <u>CAROLINE</u> Middle <u>STEVENS</u> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>YES</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <u>304-03-8838</u>		17. INFORMANT Address <u>8210-Custer Rd., Bethesda, Md.</u> Mrs. Violet Hubbard					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CORONARY DISEASE</u> 2 YRS DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <u>1969</u> P.M. <u>11</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/7</u> , 19 <u>69</u> , to <u>1/7</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ronald W. Barr</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/7/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Ronald W. Barr, M.D.</u>				22e. ADDRESS <u>10401 OLD GEORGETOWN Rd. BETHESDA, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXX</u>		23b. DATE <u>1-10-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville</u> <u>Montg.</u> <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>JAN 13 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
7557-Wisconsin Ave., Bethesda, Md.				DATE			



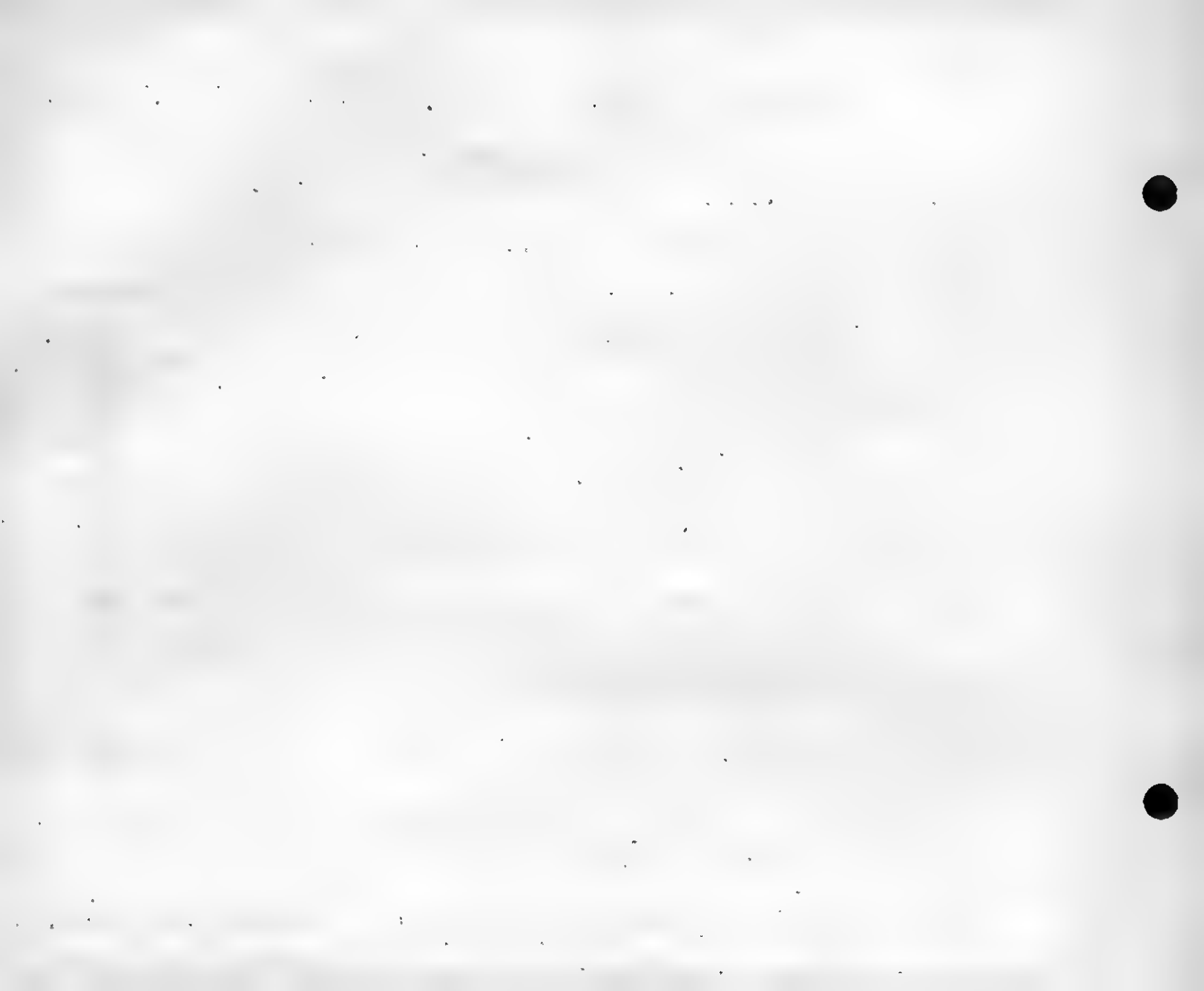
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV 11-65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last GEORGE Franklin Hughes			2a. DATE OF DEATH JAN Month 3 Day 6 Year 1969		2b. HOUR 4:19 PM
3 SEX M.	4. RACE white	5. DATE OF BIRTH 6-23-95	6. AGE (In years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) S. Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Tahoma Park,	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street-address) Washington Sanitarium & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrician	12b. KIND OF BUSINESS OR INDUSTRY building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Pr. Geo. ✓	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 706 Rittenhouse Street	
14 FATHER'S NAME First Middle Last George -- Hughes	15. MOTHER'S MAIDEN NAME First Middle Last Sarah -- Upton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. Yes	17 INFORMANT Address Hyattsville, Md. Esther M. Hughes 706 Rittenhouse Street			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCT 4125 DUE TO, OR AS A CONSEQUENCE OF (b) Thrombophlebitis of Right leg DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 8 days 12 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from April 26, 1957, to Jan 31, 1969, that (I) (we) lost saw the deceased alive on Jan 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas F. Collins M.D.		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) THOMAS F. COLLINS		22c. DATE SIGNED JAN. 31, 1969			
22e. ADDRESS 2600 QUEENS CHAPEL RD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-4-1969	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring Montgomery, Md.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue	ADDRESS Sil. Spr. Md.	25a. REC'D BY REGISTRAR FEB 7 1969	25b. REGISTRAR'S SIGNATURE H. C. ...		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First James			Middle Leon			Last Hunter Jr.			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 2b HOUR	
3 SEX Male			4 RACE W		5 DATE OF BIRTH 2-11-67		6 AGE (n years last birthday) 1 YRS 11 MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 2d HOUR		
7a BIRTHPLACE (State or foreign country) Washington DC			7b CITIZEN OF WHAT COUNTRY? UC			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Takoma Park, Md.			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San. & Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY			13c CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS?			13e STREET AND NUMBER 5607 Chillum Hts		
14. FATHER'S NAME First Middle Last James Leon Hunter			15 MOTHER'S MAIDEN NAME First Middle Last Veronica			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bronchopneumonia associated with possible allergic phenomena													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Keap			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED	
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.			ADDRESS (Street, City, Town, or County) Washington, D.C.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			JAN. 22, 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1-27-69		23c. NAME OF CEMETERY OR CREMATORY Int. obs.			23d. LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR Hagen 389 B.I. se. w. Wash. D.C.			ADDRESS			25a. REC'D BY REG. STRAR JAN 29 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared by Dr. Reap, Med. Examiner, 1/24/69

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ESTHER				HURWITZ	JAN Month Day 21 Year 69		12:45 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE				74			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
BALTIMORE MARYLAND		U.S.A.				MONTGOMERY Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING		HOLY CROSS		HOUSEWIFE		AT HOME		
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		MONTGOMERY		SILVER SPRING				8103 EASTERN AVENUE
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
AARON		SCHIFF		LIBBY ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT				
NO				MR. HAROLD HURWITZ, 2613 BLAINE AVENUE CHEVY CHASE, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>arterio-sclerosis generalized</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>hypertension, well controlled</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>I returned hip</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>1/10/68</u> , 19 <u>68</u> , to <u>1/20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
<u>M. Shapiro</u>		<u>1-21-69</u>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
M. SHAPIRO		HOLY CROSS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		1-22-69		MIKRO KODESH-BETH ISRAEL		BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				JAN 23 1969		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John M. Hutchens		2a. DATE OF DEATH 01 Month 13 Day Year 69		2b. HOUR 11:40 A M
3. SEX Male	4. RACE Cau.	5. DATE OF BIRTH 11/22/1938	6. AGE (In years last birthday) 30 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Co. Md	
10. CITY OR TOWN OF DEATH Bethesda,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nursing Home	2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student	12b. KIND OF BUSINESS OR INDUSTRY Student	
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE Maryland	13b. CITY OR TOWN Prince Geo.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8314-20th Ave.	
14. FATHER'S NAME John M. Hutchens	15. MOTHER'S M.A.DEN NAME Lottie Mildred Pullin	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown Yes		
16b. SOCIAL SECURITY NO 579 59 8262	17. INFORMANT Mrs. Evelyn McKenzie, same as deceased	Address 8314 20th Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) metastatic fibrosarcoma DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks, 16 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION Oct. 68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED fibrosarcoma leg	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 68 , to 1/13 , 19 69 , that (I) (we) last saw the deceased alive on 1/12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE David A. Chornick, MD	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 1/13/69	
22d. PHYSICIAN'S NAME (Type) David A. Chornick	22e. ADDRESS 9237 30th Silver Spring			
23a. BURIAL, CREMATION, REMOVAL (Specify) 201 1-17-1969	23b. DATE 1-17-1969	23c. NAME OF CEMETERY OR CREMATORY Prince Georges, Maryland	23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR C. Carter	ADDRESS 11 Sp...	25a. REC'D BY REGISTRAR 1/20 1969	25b. REGISTRAR'S SIGNATURE James J. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

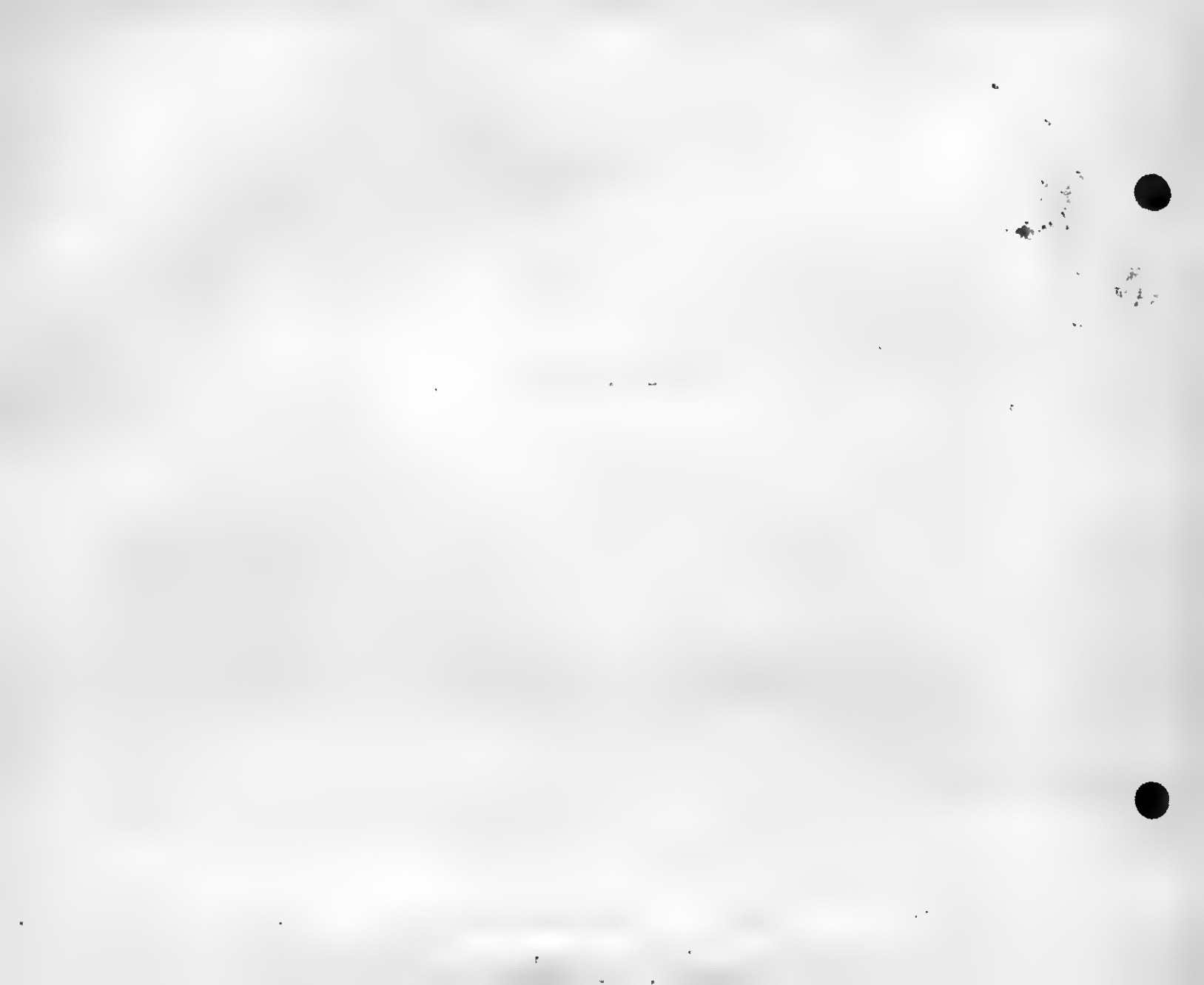
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top page of this certificate and return it to the funeral director, page 3 should be detached for use as the burial-transit permit, and in any event, within 24 hours after death.

VR 111
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
BLANCHE		E	JINGBERG	JAN 30 1969		21 P M		
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE	WHITE	8/31/84		84 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MINN	U.S.A.			MONTGOMERY				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA	SUBURBAN		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	3c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
MARYLAND	MONTGOMERY	BETHESDA	YES	5900 WALTON ROAD				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last		
JAMES			McMANUS	HOAGE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		6b. SOCIAL SECURITY NO		17. INFORMANT				
		216-40-5037		KATHRYN WEAVER - 12 MORRIS DRIVE Apt 203 - LAUREL, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>								7 days
41 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								10 years
(b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 1969, to <u>1/30</u> , 1969, that (I) (we) last saw the deceased alive on <u>1/30</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
Lewis Cahill		1/30/69		LEWIS N CAHILL				
		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
		5411 W. CLARKIN						
		BETHESDA, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/3/69		Parklawn Memorial Park		Rockville Montgomery Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler		1331 Rockville Pike, Rockville, Md. 20852		FEB 3 1969		[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Volnas Lee Izard						Jan 7 69			6:13	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		March 1 1885			83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Mississippi		USA					Montgomery Md			
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban Hosp			Dentist			Dentist	
3a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13a. CITY OR TOWN			13b. INSIDE CITY LIM-TST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET AND NUMBER	
Maryland			Montgomery			Bethesda			7608 Arrowood Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Unknown			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (name unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		none		449-64-9484		A Ethel Polk Izard		7608 Arrow Wood Rd. Bethesda		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured dissecting Aneurysm, Aortic Arch</u> 441.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Severe Arteriosclerosis, Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes.</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> , 19 <u>67</u> , to <u>1/7</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1/7</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J. Blaine Fitzgerald</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/8/69.</u>			
22a. PHYSICIAN'S NAME (Type) J. BLAINE FITZGERALD, M.D.					22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.					
23a. REMOVAL (Type) Burial		23b. DATE 1/9/69		23c. NAME OF CEMETERY OR CREMATORY Roseland Park		23d. LOCATION (City or Town) (County) (State) Hattiesburg, Miss.				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					7557 Wisconsin Ave. ADDRESS		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M-15
10M REV 11-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <i>Martha E. Jackson</i>			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year <i>Jan 20 1969</i>			2b HOUR <i>3:00</i> M		
3 SEX <i>F</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>10/13/1904</i>	6 AGE <i>64</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <i>Jan 20 1969</i>		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USIA. OCCUPATION (Kind of work done during most of work ng life, even if retired.) <i>Domestic</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Gaithersburg</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Box 273</i>
14 FATHER'S NAME First Middle Last <i>William Robinson</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Hall</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO.		17 INFORMANT <i>Mary Neal</i>		ADDRESS <i>Same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Subdural hematoma, 24 Dec 1968 (Craniotomy 24 Dec)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Laceration, traumatic, brain, right frontal lobe</i> <i>Accidental fall down stairs at home.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days - 29 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION <i>24 Dec 1968</i>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Subdural Hematoma Craniotomy</i>				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <i>7:50 AM Dec 22 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fall down stairs at home</i>				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>Box 273 - Gaithersburg</i>		City or Town <i>Montgomery Md.</i> County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Jan 22, 1969</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>1-25-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Rocky Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>CLARKSBURG Mont. Md.</i>		
24 FUNERAL DIRECTOR <i>Robert L. Snowden</i>				ADDRESS <i>Rockville Md.</i>		25a REC'D BY REGISTRAR <i>IAN 30 1969</i>		25b NOTARIES SIGNATURE <i>Robert L. Snowden</i>

321
Many thanks
Many thanks
sincerely

at, 24 Dec 1968 (Cranston)
the brain, right for
stairs, at home.

to church. Home & trip

18 Fall down 24

Box 512-6

X

11/11
1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
VIRGINIA M JACKSON						Jan 3 1969			2:15 P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
F		Cauc		6-19-18		50 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
H Va.		American				Montgomery Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San & Hosp			24 hours a day - Lesley Carpet			None		
13a US. AL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d NSIDE CITY L M 15?		
MD			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
Joe -- JACKSON			BESSIE -- ALLEN			804 Sligo Ave					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
No			579-09-1496			Mrs. Ethel Neal's			Silver Spr.		
						804 Sligo Avenue Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Metastatic carcinoma										WKS.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Primary site unknown											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work				Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from FALL, 1965, to 1/3, 1969, that (I) (we) last saw the deceased alive on 1/3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Albert H. Grollman		1/3/69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
ALBERT H. GROLLMAN		1106 FIRING ST. SILVER SPRING									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		1-7-1969		Masonic Cemetery		Middleburg, W. Virginia					
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
E. Pumphrey, Inc.		JAN 5 1969		[Signature]							
8434 Georgia Ave NE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0113

CERTIFICATE OF DEATH

01120

1. DECEASED-NAME (Type or print) Albert Earnest Johnson			2a. DATE OF DEATH Month 1 Day 7 Year 69			2b. HOUR 12:25A	
3 SEX Male		4 RACE Colored		5. DATE OF BIRTH 5-17-96		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Montgomery Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. JSUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cement Finisher Ret.		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sandy Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 17627 Norwood Road		14. FATHER'S NAME First Amos Middle Johnson Last Carrie		15. MOTHER'S MAIDEN NAME First Carrie Middle Billows Last Billows			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 214-03-9344		17. INFORMANT Medical records Department		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1951 , to Jan 7, 1969 , that (I) (we) last saw the deceased alive on Jan 6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. D. Bonifant				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D.				22e. ADDRESS Sandy Spring Medical Center, Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-11-1969		23c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL CEM.		23d. LOCATION (City or Town) (County) (State) SANDY SPRING, Montg. Md.	
24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.				25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

01135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01135

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. MODA			
Sullivan V Johnson						Month Day Year			1 6 1969			2:1m			
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			
Male		White		April 19, 1912		56 YRS						Month Day Year 1 6 1969 2:1m			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH						
WASH D.C.			USA						Montgomery County Md						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring				Holy Cross Hos.								Patent			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Md.				Montgomery Sil.Spr.								8508 16th St. #101			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last						
UNKNOWN						UNKNOWN									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
YES				WW II				579-16-2852				MADELINE JOHNSON SAME AS (3E)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary insufficiency															
4123 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary artery heart disease															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				JAN. 7, 1969							
BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City or Town or County)							
23a BURIAL, CREMATION, REMOVAL				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				1-9-1969				Blenwood Cemetery				Farmingdale NE Wash DC			
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
W.W. Chambers & Co				Silver Spring Md.				JAN 14 1969				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First EMERY			Middle THOMAS			Last KANODE			2a. DATE OF DEATH Month Day Year JANUARY 1 1969			2b. HOUR 10 P. M.		
3 SEX MALE			4 RACE WHITE			5 DATE OF BIRTH 10-19-11			6 AGE (In years last birthday) 57 YRS			11 UNWR 1 YEAR MONTHS DAYS			12 UNWR 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? AMER.			8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY CO. Md								
10. CITY OR TOWN OF DEATH TAKOMA PARK			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN + HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED			12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.								
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE Md.			13b COUNTY PRINCE GEORGES			13c CITY OR TOWN W. HYATTSVILLE			13d INSIDE CITY L.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 6631 24th Ave.					
14. FATHER'S NAME First Middle Last CHARLES KANODE			15 MOTHER'S MAIDEN NAME First Middle Last MAE GOSBURN														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. UNKNOWN 440 20 413			17 INFORMANT Mrs. Clara R. Kanode			Address 6631 24th Ave Hyattsville								
18 CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobed Pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF <u>2 days</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Malignant secondary to alcoholism</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>Jan 1</u> , 1969, that (I) (we) last saw the deceased alive on <u>Jan 1</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>James Whitlock</u>			DEGREE PHYS			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1-2-69								
22d. PHYSICIAN'S NAME (Type) James Whitlock			22e. ADDRESS 7717 CARROLL AVE., TR. PK., MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 4. 1969			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Md								
24. FUNERAL DIRECTOR <u>Charles Judge</u>			25. REC'D BY REGISTRAR JAN 6 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

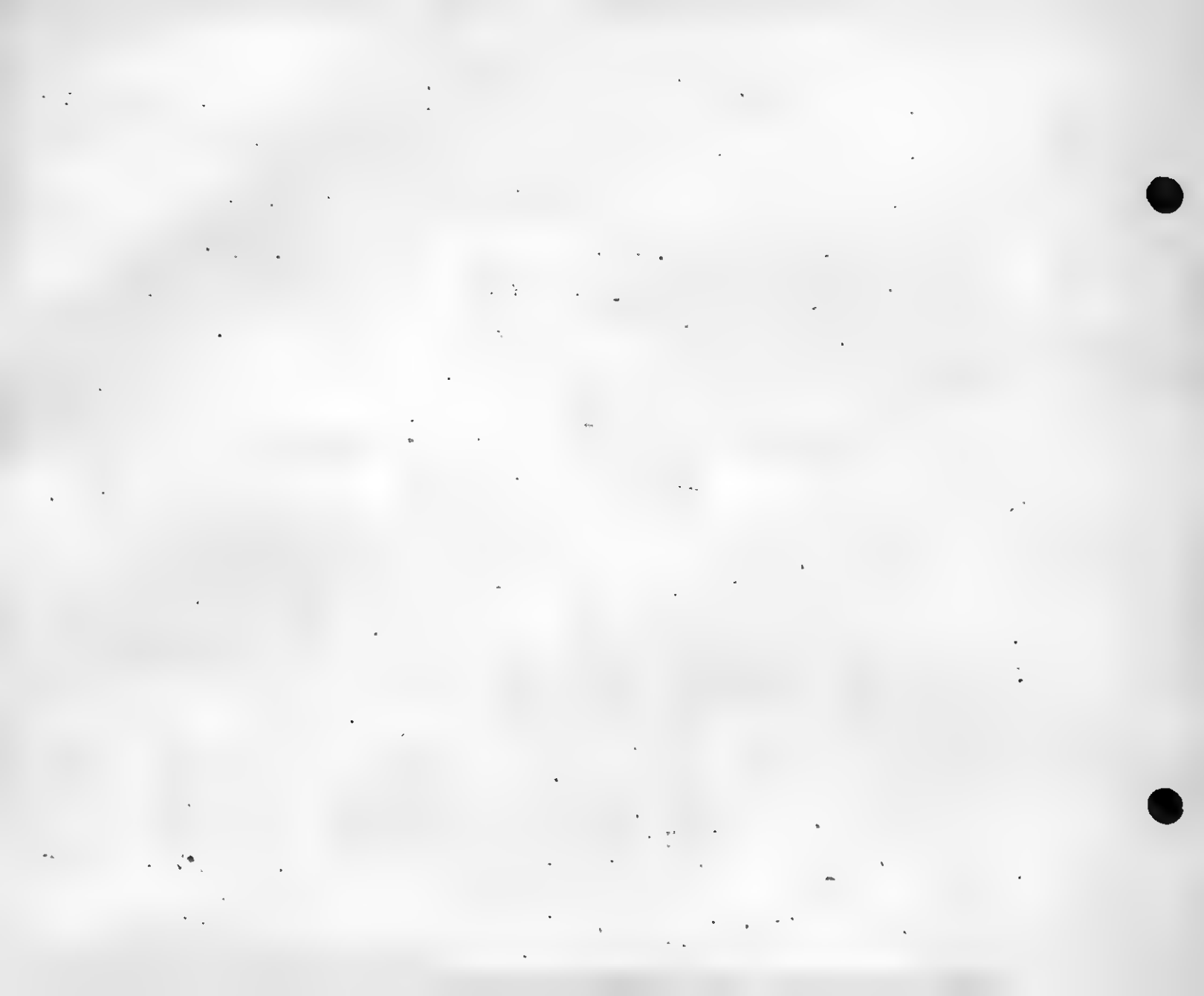
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Witnessed & Dr. Robert T. Thibodeau

01133
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
01133
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Montgomery David</i> First Middle Last			2a. DATE OF DEATH <i>Jan 13 1969</i> Month Day Year			2b. HOUR <i>7:15 P</i> M							
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>5/30/95</i>			6 AGE (in years lost birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (Store or foreign country) <i>DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md							
10. CITY OR TOWN OF DEATH <i>SIL. SPRING</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sylvan Manor</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>P.O. EMPLOYEE</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>USGOUT</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>MONTGOMERY</i>			13c. CITY OR TOWN <i>ROCKVILLE</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>1480 WISC AVE.</i>	
14. FATHER'S NAME First Middle Last <i>SIMON - KAPLAN</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>REBECCA BITTERMAN</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>-</i>			17. INFORMANT <i>ROSE KAPLAN</i> Address <i>(same as 13a)</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i>													
2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i>													
(c) <i>Diabetes Mellitus</i>										36 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 7</i> , 19 <i>69</i> , to <i>Jan 13</i> , 19 <i>69</i> , that (I) <i>we</i> last saw the deceased alive on <i>Jan 7</i> , 19 <i>69</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> (did) <i>did not</i> view the body after death.													
22b. SIGNATURE <i>Robert T. Thibodeau</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>Jan 13-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBODEAU</i>			22e. ADDRESS <i>ROCKVILLE, MD 20852</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>1-15-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>NATL MEM PARK</i>			23d. LOCATION (City or Town) (County) (State) <i>FALLS CHURCH VA.</i>				
24. FUNERAL DIRECTOR <i>Charles F. Hone</i>			ADDRESS <i>4017 9th St NW Wash DC</i>			25a. REC'D BY REGISTRAR <i>JAN 16 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LENA			First Middle Last			2a. DATE OF DEATH Month 1 Day 6 Year 69			2b. HOUR 3:20 PM		
3 SEX Female			4. RACE WHITE			5. DATE OF BIRTH 6/27/1891			6. AGE (In years) last 77 YRS.		
7a. BIRTHPLACE (State or foreign country) Russia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery County Md.		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 8484 16th ST.			14. FATHER'S NAME First BENJAMIN Middle NEEDLEMAN Last DORA			15. MOTHER'S MAIDEN NAME First DORA Middle NEEDLEMAN Last DORA			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 577-34-5496-A			17. INFORMANT Adopt Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF, (b) Chronic Bronchitis DUE TO, OR AS A CONSEQUENCE OF, (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19 69 , to Jan 6th , 19 69 , that (I) (we) last saw the deceased alive on Jan 6th , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Robert Kramer			DEGREE PHYS			MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/6/69		
22d. PHYSICIAN'S NAME (Type) Robert Kramer			22e. ADDRESS 8484-16th St - SS - Md.			23a. BURLIA, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Jan. 7, 1969		
23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery			23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland			24. FUNERAL DIRECTOR Donald M. Stein			25a. REC'D BY REGISTRAR St., N.W., Wash., D.C.		
25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JAN 9 1969			25c. REGISTRAR'S SIGNATURE Charles Judge			25d. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Decomposed case with Dr. John B. Ryland

01135

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01135

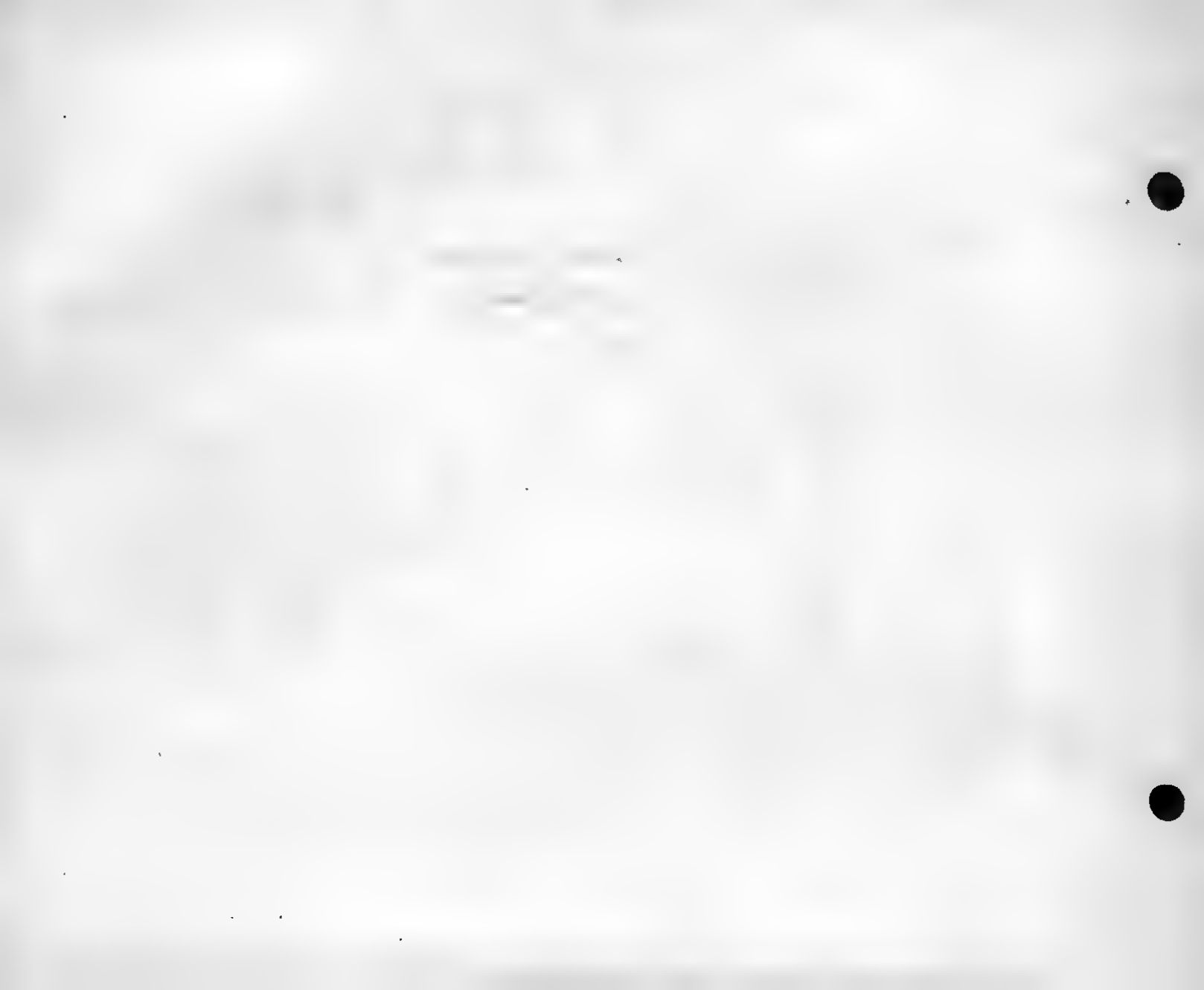
1. DECEASED NAME (Type or print) <i>Lillian F Keefe</i>			2a. DATE OF DEATH Month <i>January</i> Day <i>21</i> Year <i>1969</i>			2b. HOUR <i>1:30</i> P.M.			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>9/13/96</i>		6. AGE (In years last birthday) <i>72</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>—</i>		13c. CITY OR TOWN <i>D.C.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2745 Macomb St. N.W.D.C.</i>	
14. FATHER'S NAME First Middle Last <i>JOHN ——— KEEFE</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>NELLIE ——— MULUMPHY</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO <i>011101813</i>			17. INFORMANT <i>TILFORD DUDLEY 2942 Macomb St. N.W. D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hodgkin's disease.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 mo.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>removal of spleen, adenitis, Hodgkin's disease</i>									
19a. DATE OF OPERATION <i>Feb 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Prostate gland in neck removed as 18 above</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1961</i> , 19 <i>—</i> , to <i>Jan 2, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 2, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>C.P. Ryland</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1-21-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>4400-49th St. N.W. C.P. RYLAND Washington D.C. 20016</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE <i>JAN 28, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CREMATORY</i>		23d. LOCATION (City or Town) (County) (State) <i>COLMAR MANOR, PRINCE GEORGES CO., MARYLAND</i>			
24. FUNERAL DIRECTOR <i>W.W. Chambers</i>		ADDRESS <i>Biv. Dale, Md. 5</i>		25a. REC'D BY REGISTRAR <i>DATE B 6 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) LEON			First Middle Last			2a. DATE OF DEATH Month 1 Day 8 Year 69			2b HOUR 1:15 M		
3. SEX Male			4 RACE N.			5. DATE OF BIRTH 12/24/03			6. AGE (In years last birthday) 65 YRS.		
7a BIRTHPLACE (State or foreign country) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nurs. Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.			13b COUNTY			13c CITY OR TOWN Washington			13d. ASIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME WALTER			First Middle Last			15 MOTHER'S MAIDEN NAME SARAH			First Middle Last MONTAGUE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17 INFORMANT Adeline Keeve - wife			Address -1300 Constitution Ave.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 Resp. artery aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Spinal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the lung									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/8/69 - 2 minutes aug. 68 7/21/67		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED metastatic Ca of brain			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from November 19 68 to 1/8 , 19 69 , that (I) (we) last saw the deceased alive on 12/28 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1/8/69		
22d. PHYSICIAN'S NAME (Type) MORTIN EICHLER, MD.						22e ADDRESS 911 SILVER LANE AVE. SIL SPR.					
23a BURIAL, CREMATION REMOVAL (Specify) Burial			23b DATE 1/12/69			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) Northumberland, Virginia		
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Road						25a. REC'D BY REGISTRAR NAME 13 1969			25b. REGISTRAR'S SIGNATURE [Signature]		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-14-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
0114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1137

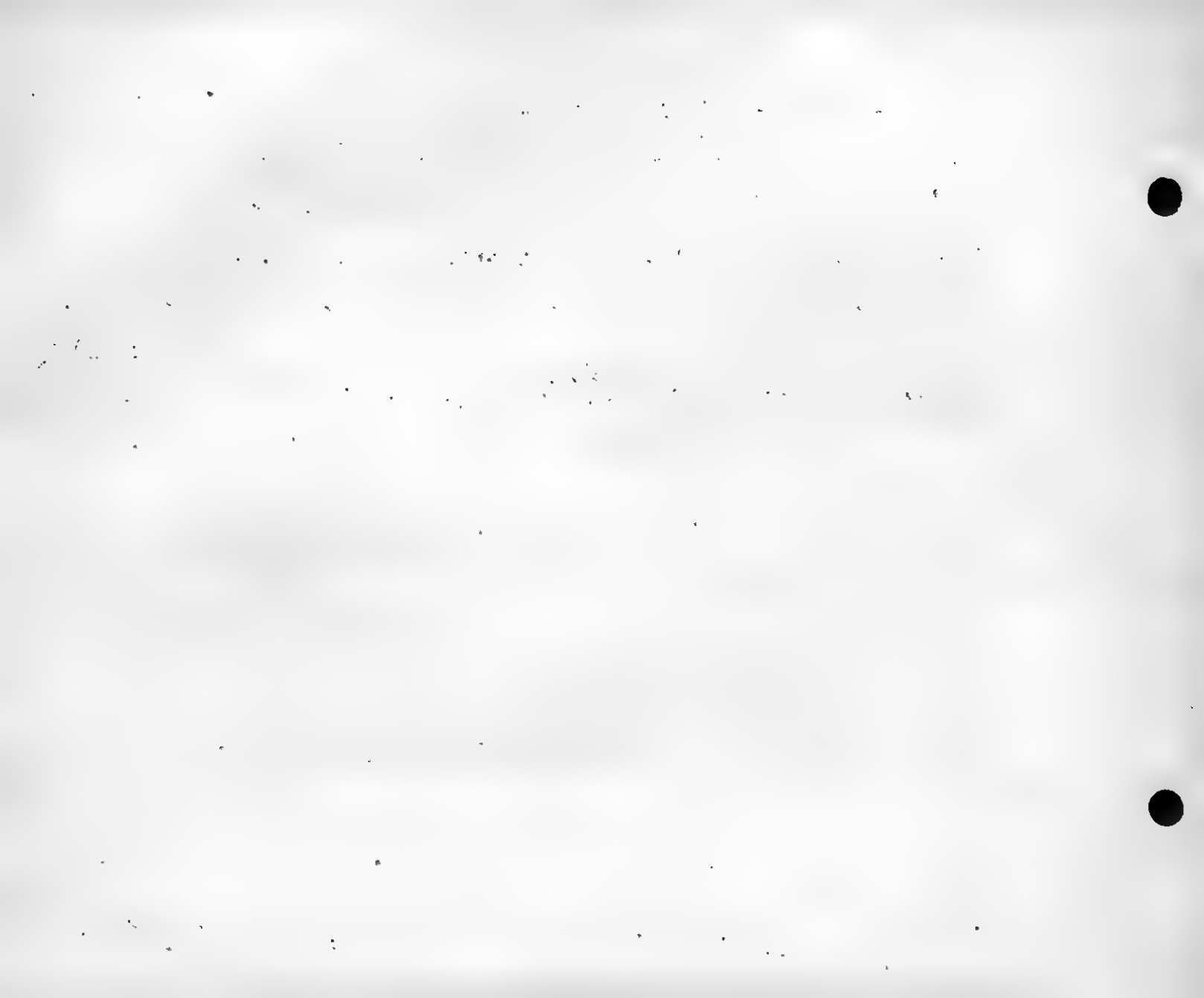
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF EST. MATED	Month	Day	Year	2b HOUR
MARK E. Keister					<input checked="" type="checkbox"/> 1-26 1969				9:30 A.M.
2 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month		Year	2d HOUR
male	White	8-13-17	51 YRS	5	13	1		26	9:30 A.M.
7a BIRTH-PLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. VA.	U. S. A.			Montgomery Md					
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda	SUBURBAN		LAB. BUILD. ENGINEER		N.I.H.				
13a USJA. RESIDENCE (Where deceased lived, if institution admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER					
md.	mont.	Rockville	YES <input type="checkbox"/> NO <input type="checkbox"/>	8415 Victory Lane					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Bert			Keister	Zeffie			Jackson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No		578-16-9937		Ethel - Wife		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction; 4109 DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
		19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MED. CA. EXAMINER <input type="checkbox"/>		ASS STANT MED. CA. EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, State, or County)					
BELDEN R. REAP		M.D.		JAN. 26, 1969					
23a BURIAL, CREMATION, OR OTHER (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		1-29-69		Ft. Lincoln		Bladensburg Md.			
24 FUNERAL DIRECTOR Robert A. Pumphrey				ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
7557-Wisconsin Ave., Bethesda, Md.						DATE JAN 29 1969		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) ^{First} William ^{Middle} (none) ^{Last} Kessler					2a. DATE OF DEATH Month 7 Day 69 Year			2b. HOUR 6:30 P.M.	
3 SEX male		4 RACE White		5 DATE OF BIRTH 9-27-05		6 AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? America (us)		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp. Center		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Barber		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admssion) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7425 Piney Branch Rd	
14. FATHER'S NAME ^{First} Peter ^{Middle} ^{Last} Kessler			15. MOTHER'S MAIDEN NAME ^{First} ELLIAN ^{Middle} FRIEDLANDER ^{Last}						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 57-446359		17. INFORMANT Washington San & Hosp Records		Address Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure. 410-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours.									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased, from Jan 1968, to Jan 7, 1969, that (I) (we) last saw the deceased alive on Jan 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Morton Altschuler M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-7-69			
22d. PHYSICIAN'S NAME (Type) Morton Altschuler, M.D.				22e. ADDRESS 9205 New Hampshire Ave. S.W. Washington					
23a. BURIAL CREMATION, ETC. (Type)		23b. DATE 1-11-1969		23c. NAME OF CEMETERY OR CREMATORY Geo Wash Mem Pl Cmn		23d. LOCATION (City or Town) Riggs Rd		(County) (State)	
24. FUNERAL DIRECTOR W.W. Chambers G				ADDRESS 1400 Chapin St N.W. Wash D.C.		25a. REC'D BY REGISTRAR JAN 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01143

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01139

1 DECEASED-NAME (Type or Print) <i>James F. Kelly</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>Jan 9 1969</i>			2b HOUR <i>10:12 AM</i>		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>April 24 1952</i>	6 AGE (In years last birthday) <i>16</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <i>Jan 9 1969</i>		
7a BIRTHPLACE (State or foreign country) <i>East. DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Helper</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Roofing</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE <i>Md.</i> COUNTY <i>Prince George</i>		13c CITY OR TOWN <i>Landover</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>3406 Lodge Park Rd</i>		
14 FATHER'S NAME First Middle Last <i>George E. Kelly</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Rose Burkhard</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>George E. Kelly Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laceration of Brain</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Fracture of Skull</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Trauma from Fall</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>5 days</i> <i>5 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year <i>9:03 AM Jan 4 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell off ladder at work striking head</i>			
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>Home</i>		21f LOCATION Street or R.F.D. No City or Town County State <i>4011 Olvin St. Chever Chase Montgomery MD</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John B. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Jan 9 1969</i>		
EXAMINER'S NAME (Type) <i>John H. BALL</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Jan. 11-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Bladensburg, Maryland</i>		
24 FUNERAL DIRECTOR <i>Simmons Bros.</i>			ADDRESS <i>Wash</i>			25a REC'D BY REGISTRAR DATE <i>JAN 13 1969</i>		
						25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		



1
Cleared with Med Exam to be signed by Dr. Fitzgerald
To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0114
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
Item #586, Film 3109 1/30/69

1 DECEASED-NAME (Type or print) MARY IRENE		First Middle Last		2a DATE OF DEATH 1-4-69 Month Day Year		2b HOUR 1:45 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 5-18-78 May 18, 1895		6 AGE (In years last birthday) 77 1/2 YRS	
7a BIRTHPLACE (State or foreign) WASH D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT. CO.	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WASH SAN & HOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admn ssion) STATE MD.		13b COUNTY MONT.		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME AUTHER First Middle Last		15 MOTHER'S MAIDEN NAME ANNA MULLORY First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT MRS. DUKE DAUGHTER 805 SEEKS LANE SS MD. Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE-ARTERIOSCLEROTIC VAS. DIS. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min to 0
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from December 19 1968 , to Jan 19 1969 , that (I) (we) last saw the deceased alive on December 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard A Fitzgerald MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED 1-4-69			
22d. PHYSICIAN'S NAME (Type) BERNARD A FITZGERALD				22e ADDRESS 217 Ann. Blk E, Silver Sp. Md.			
23 BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 1-7-69		23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d LOCATION (City or Town) (County) (State) 3201 BLADENSBURG RD. PG. MD	
24 FUNERAL DIRECTOR A. W. Chambers Inc ADDRESS 1400 Howard St. H. D.C.				25a REC'D BY REGISTRAR JAN 10 1969 DATE		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-10
30M REV. 1-68

31140

CERTIFICATE OF DEATH

31141

1 DECEASED-NAME (Type or print) Charles Blanchard Klopfer			2a DATE OF DEATH Month January Day 25 Year 1969			2b HOUR 9:00 P M	
3 SEX Male		4 RACE white		5 DATE OF BIRTH 7 April 1905		6 AGE (In years last birthday) 63 YRS.	
7a BIRTHPLACE (State or foreign country) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of waking life, even if retired) Painter		12b. KIND OF BUSINESS OR INDUSTRY maintenance	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE District of Columbia		13b COUNTY 13b		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 404 East Capitol Street, N.E							
14 FATHER'S NAME First Frank Middle Klopfer Last Blanchard			15 MOTHER'S MAIDEN NAME First Caroline Middle Blanchard Last Blanchard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO Not available		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrosis of pons, cerebellar peduncles and 2050 DUE TO, OR AS A CONSEQUENCE OF (b) Acute granulocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF (c) cerebral white matter. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 6, 1968 , to Jan. 25, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 25, 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE Alan Snyder MD				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 26 January 1969	
22d. PHYSICIAN'S NAME (Type) Alan L. Snyder, MD				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-29-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Southland md	
24. FUNERAL DIRECTOR Lee Funsch		ADDRESS 300 - 4 St. M.E. D.C.		25a RECEIVED BY REGISTRAR JAN 31 1969		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death, notified.

University Nursing Home advises Dr. Belden Reap, Montgomery County Dep. Me.

01145

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01142

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CLYDE PHILLIP KNAPP			2a. DATE OF DEATH Month 1 - Day 23 - Year 1969			2b. HOUR 6:00 P.M.								
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 1/12/1905		6. AGE (In years lost birthday) 64 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN 0				
7a. BIRTHPLACE (State or foreign country) WESTFIELD NY			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH WHEATON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CENTINEX NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE N.Y.			13b. COUNTY MT. KISCO			13c. CITY OR TOWN MT. KISCO			13d. INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 169 MAIN STREET		
14. FATHER'S NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO 086-18-9208			17. INFORMANT PHILIP F. KNAPP - BORN 6-4-06, CHARRS-APP. NY.			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 411.7 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1/17 , 19 69 , to 1/23 , 19 69 , that (I) (we) last saw the deceased alive on 1/20 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE David Morowitz, M.D.			22c. DATE SIGNED 1/23/69			22d. PHYSICIAN'S NAME (Type) David Morowitz, M.D.								
22e. ADDRESS 2309 Shorefield Drive, Wheaton, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1-30-69			23c. NAME OF CEMETERY OR CREMATORY ST. FRANCIS CEM.			23d. LOCATION (City or Town) (County) (State) MT. KISCO, N.Y.					
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, 5130 WIS. AVE, WASH, D.C.			25a. REC'D BY REG. STRAR AFEB 3 1969			25b. REG. STRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

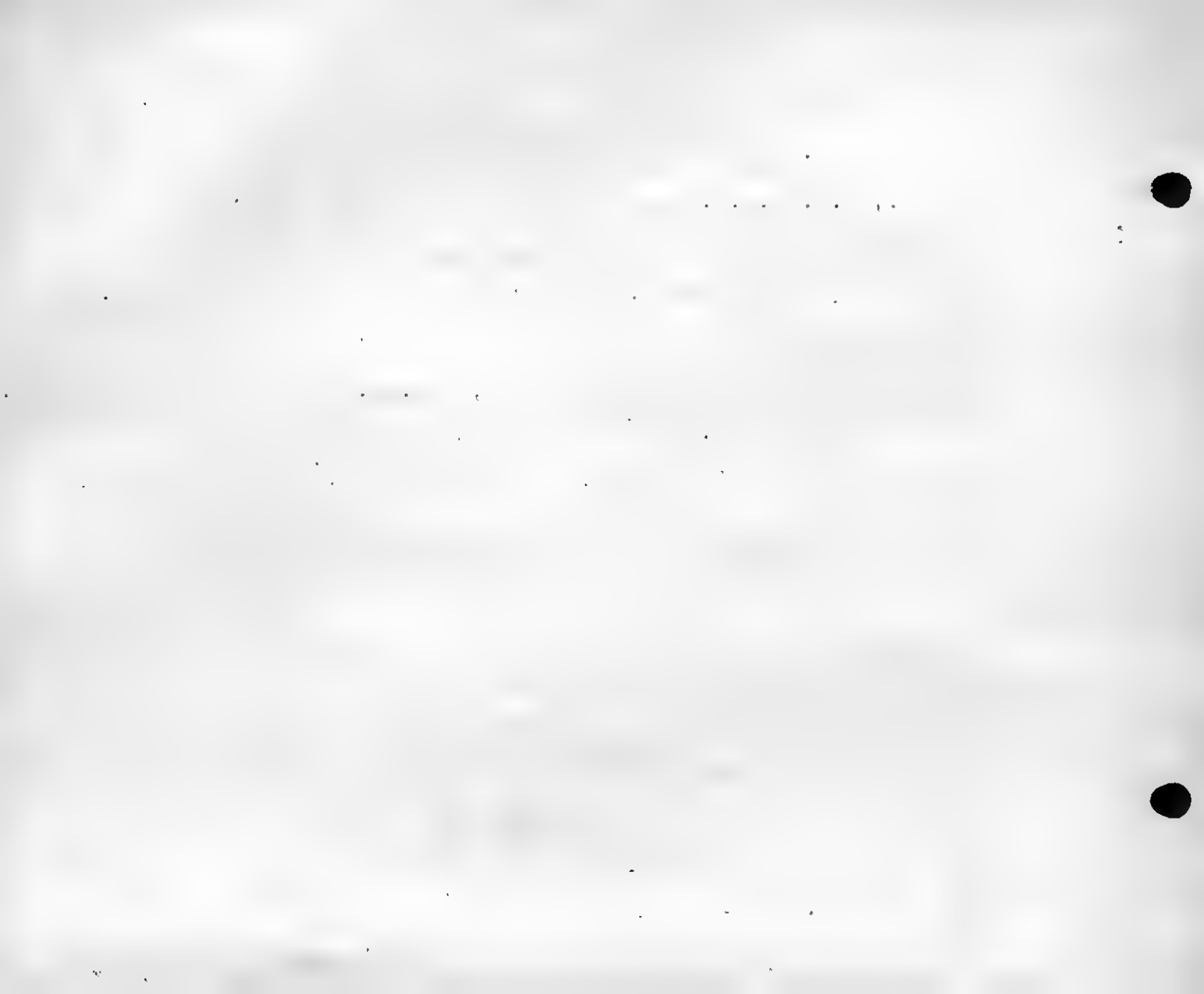
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1 DECEASED NAME (Type or print) First Middle Last STANLEY M Kotas									
2a. DATE OF DEATH Month Day Year JAN 10 1969		2b. HOUR 2:00 PM							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5/1/82		6. AGE (In years last birthday) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 8 11	
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN				12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Grocer		12b. KIND OF BUSINESS OR INDUSTRY SELF	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8714 IRVINGTON AVE	
14. FATHER'S NAME First Middle Last STANLEY Kotas		15. MOTHER'S MAIDEN NAME First Middle Last PAULINE Marzaj Grodowska		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No					
16b. SOCIAL SECURITY NO. 070-05-2095		17. INFORMANT Address VIRGINIA DZIROWSKI - DAUGHTER - SAME -							
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Septic									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Pneumonia									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Aspiration									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASHD, CHF, Angioma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-14 , 19 69 , to 10-JAN , 19 69 , that (I) (we) saw the deceased alive on 9 Jan , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE John S. Saia		22c. DATE SIGNED 10 Jan 69		22d. PHYSICIAN'S NAME (Type) John S. Saia					
22e. ADDRESS 809 Viers Mill Rd. Rockville, Maryland		22f. ADDRESS 809 Viers Mill Rd. Rockville, Maryland							
23a. BURIAL CEMETERY St. Stanislaus Cem.		23b. DATE 1-13-69		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION (City or Town) (County) (State) Cheekowago N.Y.		23e. LOCATION (City or Town) (County) (State) Cheekowago N.Y.	
24. FUNERAL DIRECTOR Robert A. Pumphrey		24b. ADDRESS 7557-Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) First Middle Last Lillian Mae Kreis						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 1 16 1969		2b HOUR M			
3 SEX Fe	4 RACE Cauc.	5 DATE OF BIRTH 3/9/1882	6 AGE (in years last birthday) 86 YRS	F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 1 16 1969		2d HOUR 9 50 p.m.	
7a BIRTHPLACE (State or foreign country) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Rockville			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) at home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Montg.		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 13705 Lionel La.		
14 FATHER'S NAME First Middle Last John Wright						15 MOTHER'S MAIDEN NAME First Middle Last Louisa Carroll					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO none			17. INFORMANT ADDRESS Niece, Eva. M. Whitsell 13705 Lionel La.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Keap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED Jan. 17, 1969		
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, county) Washington					
23a BURIAL, CREMATION, or other disposition BURIAL		23b DATE 18 JAN 1969		23c NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY			23d LOCATION (City or Town) (County) (State) WASHINGTON DC.				
24 FUNERAL DIRECTOR RINALDI FUNERAL HOME, INC. 7400 GEORGIA AVE. N.W. DC 20014						25a REC'D BY REGISTRAR DATE 20 1969		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

01145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1145

1 DECEASED-NAME (Type or Print)		First ANDREW Middle GRATIAN Last KUTTNER		2a DATE KNOWN OF ESTI- DEATH: MATED <input checked="" type="checkbox"/> 1-17-69 19		2b HOUR 10:30 AM	
3 SEX MALE	4 RACE W	5 DATE OF BIRTH 10-6--36	6 AGE (in years just birthday) 32 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 1-17-69 Year 19 10:30 AM	
7a BIRTHPLACE (State or foreign country) ITALY		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH SILVER SPRINGS		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) CONTRACT ADMINISTRATOR		12b KIND OF BUSINESS OR INDUSTRY	
13a. US. AL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE MD.		13b COUNTY PG. CO.		13c CITY OR TOWN BELTSVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 13108 GREENMOUNT AVE		14 FATHER'S NAME First STEPHAN G Middle KUTTNER Last		15. MOTHER'S MAIDEN NAME First EVA Middle ILLCH Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO (If give war or dates of service) 578444162		17. INFORMANT LUDWIG KUTTNER 5803 CHEVY CHASE PKWY N.W. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries incurred DUE TO, OR AS A CONSEQUENCE OF (b) in auto accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 10:00 PM 1-17 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased driving alone lost control of car and struck bridge support.			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No Silver Spring		City or Town County State Montgomery Md.	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Belden R. Peapack MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED JAN. 17, 1969	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE JAN 21, 1969		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d LOCATION (City or Town) (County) (State) WHEATON MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD		25a REC'D BY REGISTRAR DATE J 22 1969		25b REGISTRAR'S SIGNATURE Charles J. J...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Virginia</i> First <i>(N)</i> Middle <i>La Guardia</i> Last		2a. DATE OF DEATH Month <i>Jan</i> Day <i>13</i> Year <i>1969</i>		2b. HOUR <i>3:30</i> M
3 SEX <i>Female</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>6/6/1898</i>		6 AGE (in years last birthday) <i>70</i> YRS
7a. BIRTHPLACE (State or foreign country) <i>Argentina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>
12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>				
13a. USUAL RESIDENCE (Where deceased addressed) STATE <i>New York</i>		13b. COUNTY <i>Queens</i>	13c. CITY OR TOWN <i>Jackson Heights</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER <i>3743 - 90th St.</i>				
14. FATHER'S NAME First <i>Benaro</i> Middle <i>Ben</i> Last <i>Guadalupe</i>		15. MOTHER'S MAIDEN NAME First <i>Angela</i> Middle <i>Stefi</i> Last <i>Stefi</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>109-36-4480</i>	17. INFORMANT <i>Sister - Mrs. Stalia La Guardia</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, old and recent</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis, old and recent</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe coronary arteriosclerosis.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 mo</i> <i>4 mo</i> <i>Years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <i>1-10, 19-69</i> to <i>1-13, 19-69</i> , that (I) (we) last saw the deceased alive on <i>1-12, 19-69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE <i>Stanley M. Silverberg M.D.</i>		22c. DATE SIGNED <i>1-13-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>STANLEY M. SILVERBERG</i>		22e. ADDRESS <i>5201 Conn. Ave., N. W. Washington, D. C.</i>		
23a. XXXX CREMATION, XXXX (Spec. fr.)		23b. DATE <i>1-15-69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	
23d. LOCATION (City or Town) <i>Suitland</i>		(County) (State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>JAN 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

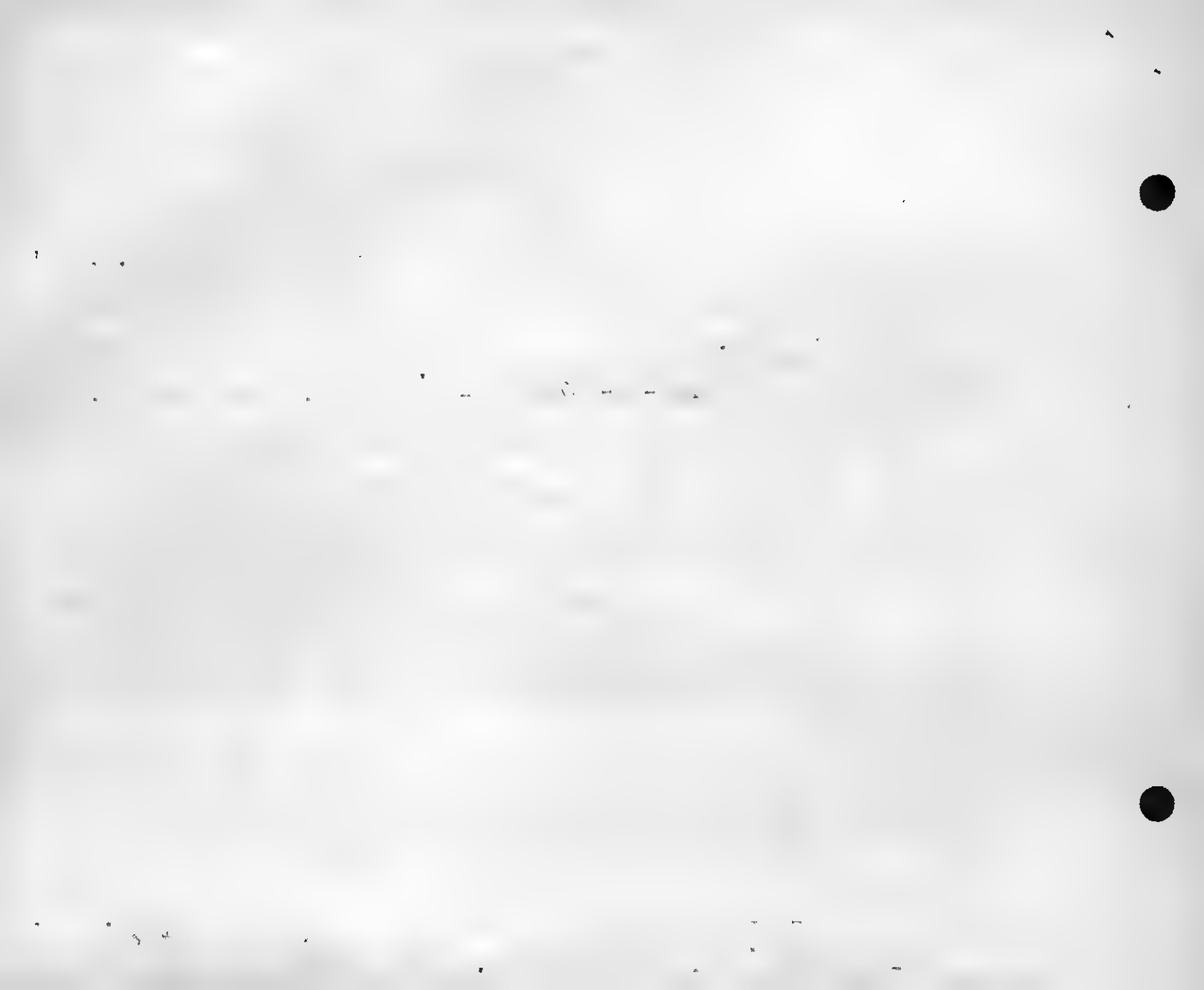
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the above certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01154												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
1. DECEASED-NAME (Type or print) <i>Claude W LANE</i>												2a. DATE OF DEATH <i>JAN. 10 1969</i>												2b. HOUR <i>12:15</i>	
3. SEX <i>MALE</i>			4. RACE <i>WHITE</i>			5. DATE OF BIRTH <i>8-27-1883</i>			6. AGE (In years last birthday) <i>85</i> YRS			IF UNDER 1 YEAR MONTHS <i>4</i> DAYS <i>13</i>			IF UNDER 24 HRS HOURS <i></i> MIN <i></i>										
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Montgomery</i>													
10. CITY OR TOWN OF DEATH <i>Bethesda</i>						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>						12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Dept of Agriculture</i>						12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE <i>MD</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Bethesda</i>						13d. INSIDE CITY (HMS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7405 River Rd</i>																	
14. FATHER'S NAME First <i>Luther</i> Middle <i>A.</i> Last <i>Lane</i>				15. MOTHER'S MAIDEN NAME First <i>Pocohontas</i> Middle <i>Saffer</i> Last <i></i>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <i>215-36-5672</i>				17. INFORMANT <i>Mr. Luther Lane</i> Address <i>7405-River Road., Bethesda, Md.</i>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardio-respiratory failure</i> <i>342X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last (b) <i>parkinsonism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized arteriosclerosis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i> <i>204.5</i> <i>204.5</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>53</i> , to <i>10 JAN</i> , 19 <i>69</i> , that (I) (we) (last saw the deceased alive on <i>9/13/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE <i>John M. Wyman</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <i>1/10/69</i>																	
22d. PHYSICIAN'S NAME (Type) <i>JOHN M. WYMAN M.D.</i>				22e. ADDRESS <i>7801 NORFOLK AVE BETHESDA, MARYLAND 20814</i>																					
23a. BURIAL CREMATION REMOVAL (Specify) <i>XXXX</i>				23b. DATE <i>1-13-69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg. Md.</i>													
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i>												25a. REC'D BY REGISTRAR <i>JAN 15 1969</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HO JR		
Edith Ekine Larkin						Month	Day	Year	9 ³⁷ AM		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	White		5-20-22			46 YRS		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
md		Usa				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Wash Jan & Hosp			Secretary			church			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3a. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER			
md		Montgomery		Takoma Park				8201 Flower Ave.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last		
Clyde					Schull	Edith			Hevener		
16a. WAS DECEASED EVER Yes (nd, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/>		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
N U.S. ARMED FORCES? (If yes give war or dates of service)				Hospital Record							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor - gliomatous type											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-19, 1969, to 1-30, 1969, that (I) (we) last saw the deceased alive on 1-30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)							
T. H. LUNDSTROM, M.D.		1-30-69		T. H. LUNDSTROM, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REGISTRAR'S SIGNATURE			
Burial		Feb. 3. 1969		Bro. Washington Cemetery		Adelphi, Maryland		FEB 3 1969			
24. FUNERAL DIRECTOR		ADDRESS		25a. REGISTRAR'S SIGNATURE		DATE		25b. REGISTRAR'S SIGNATURE			
John Haller		254 Carroll Ave. NW		AC		FEB 3 1969					

01153

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) MARC		First Middle Last LA RUE		2a. DATE OF DEATH Month Day Year JUN 15 1969			2b. HOUR 7:15 A		
3. SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 8-13-1951		6. AGE (In years lost birthday) 17 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Dist. of Columbia		7b CITIZEN OF WHAT COUNTRY? U.S.H		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY Prince Georges		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7200 Woodland Drive	
14 FATHER'S NAME First Middle Last ROBERT E LA RUE		15. MOTHER'S MAIDEN NAME First Middle Last MARY V FITZSIMMONS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b SOCIAL SECURITY NO -		17 INFORMANT Address MRS. MARY V. LA RUE, MOTHER					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4/11 X DUE TO, OR AS A CONSEQUENCE OF Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Suppurative Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Influenza (d)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Palsy Severe									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/12/69 , 19 69 , to 1/14/69 , 19 69 , that (I) (we) last saw the deceased alive on 1/14/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Vincent L. O'Donnell		22c. DATE SIGNED 1/15/69		22d. PHYSICIAN'S NAME (Type) VINCENT L. O'DONNELL					
22e ADDRESS 5415 N. CEDAR LA., BETHESDA, M.D.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
CREMATION 1-17-1969 CEDAR HILL CREMATORY		1-17-1969		SETH AND FAME BERNES CO INC		SETH AND FAME BERNES CO INC			
24. FUNERAL DIRECTOR JOSEPH GALLERS SONS, INC		25a ADDRESS 5130 W. BALTIMORE		25b JAN 20 1969		25c REGISTRAR'S SIGNATURE [Signature]			
24b ADDRESS 1000 N.W. WISSE, D.C.		25d DATE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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0115

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1150

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John Edward Leonhart			2a. DATE OF DEATH Month 1 Day 4 Year 69			2b. HOUR 7 P.M.				
3 SEX male		4 RACE white		5. DATE OF BIRTH 6-6-93		6 AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? Amer		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Takoma Park.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Naval Research Lab.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) STATE Md.			13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8210 16th Ave.	
14. FATHER'S NAME First Edward Middle Leonhart Last			15. MOTHER'S MAIDEN NAME First unknown. Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Navy W.W.I.			16b. SOCIAL SECURITY NO 216-40-8843		17. INFORMANT Address Med. records - Wash. San. Hosp.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 2441 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic lymphatic leukemia DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDI ON GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med col examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 12/14 , 19 68 , to 1/4 , 19 69 , that (1) (we) lost saw the deceased alive on 1/4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lewis William Dennis MD						DEGREE MD		22c. DATE SIGNED 1/5/69		
22d. PHYSICIAN'S NAME (Type) Lewis William Dennis MD						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Jan 9, 1969		23c. NAME OF CEMETERY OR CREMATOR Edgar Hill			23d. LOCATION (City or Town) (County) (State) Annapolis P. Res. Md.		
24. FUNERAL DIRECTOR Arthur Walters			ADDRESS 254 Federal St			25a. REC'D BY REGISTRAR Jan 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 4. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			2b HOUR
Gertrude Agnes Loxcen						Month Day Year			7A M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	2d HOUR
Female	White	8-8-99	69 YRS.					Month Day Year	7A M
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Minnesota		USA				Montgomery		Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington San & Hosp						
3a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13a CITY OR TOWN			3b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		3c STREET AND NUMBER	
Md			Prince George's Hyattsville					8223 14th Ave.	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Charles RANEY						Catherine LA VELLE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS #13
No			UNK.			Hospital Chart + JOHN LOXCEN (SON)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage.									
4310 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
Essential Hypertension — Diabetes Mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			JAN. 12, 1969			
Belden R. RANEY, M.D.			DEPUTY MEDICAL EXAMINER			ADDRESS (City or Town or County)			
23a BURIAL OR CREMATION, REMITAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCAT ON (City or Town) (County) (State)
BURIAL			1/15/1969			Gate of Heaven			Wheaton, Maryland
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE
Wm. Altman			4748 Wisconsin Ave NW			JAN 14 1969			
			WC 20016			DATE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14. Cleared to Medical Examiner

01150

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01152

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles William Lienau			2a. DATE OF DEATH Month 1 Day 5 Year 69			2b. HOUR 10:46 AM					
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH 10/22/03		6. AGE (In years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY Electronic					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 15220 Rosecroft Road			
14. FATHER'S NAME First Charles Middle W. Last Lienau, St.			15. MOTHER'S MAIDEN NAME First Mary Middle -- Last McManns			Address Rockville, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No		(If yes give war or dates of service) --		16b. SOCIAL SECURITY NO. 061-01-5522		17. INFORMANT Laura G. Lienau 15220 Rosecroft Road					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Hemorrhage, cerebral DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) 1-2 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 4 , 1969, to Jan 5 , 1969, that (I) (we) last saw the deceased alive on Jan 5 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Smith M.A.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/5/69			
22d. PHYSICIAN'S NAME (Type) A.W. SMITH				22e. ADDRESS 13018 GEORGIA AVE LINTHROP, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-8-1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Md.					
24. FUNERAL DIRECTOR Warner E. Purphrey, Inc. 8434 Georgia Avenue				ADDRESS il. Spr., Md.		25a. JAR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Ellen			M		Lindman				1 - Month 18 Day 1969		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7b. UNDER 1 YEAR		
Female		White		10-27 1912			56 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
New York		America USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross			Telephone silicator			Telephone Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Prince Georges			Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		6000-42nd Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
George R. Ellmaker			Lillian Mae Hill								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT					
No			578104037			Edmund H. Lindman New Carrollton Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) Acute Bronchopneumonia										3 wks.	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Pulmonary emphysema										3 yrs.	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3 Jan. 1969, to 16 Jan. 1969, that (I) (we) last saw the deceased alive on 1-18-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED		
Frederick Barr									1-18-69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Frederick Barr, M.D.			4500 College Ave, College Park, Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			Jan 21, 1969			Bryce Funeral Home			Troy Rensselaer N Y		
24. FUNERAL DIRECTOR			F. Gasch's Sons Hyattsville Md			25a. RECEIVED BY REGISTRAR DATE			25b. RECEIVED BY REGISTRAR DATE		
						JAN 23 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last ESTHER NONE Livingston			2a. DATE OF DEATH Month 15 Day 19 Year 1969			2b. HOUR 10:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-10-88		6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? AMERICAN U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SANITARIUM & HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10109 McKinney Ave. Apt. #3	
14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO 577-10-9391D			17. INFORMANT HOSPITAL RECORDS TAKOMA PARK MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1674 Cardiac arrest due to atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction due to (c) Perforation of bowel - Inoperable DUE TO, OR AS A CONSEQUENCE OF (c) Venous Poisoning						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal failure									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from Jan 13, 1969, to Jan 15, 1969, that (I) (we) lost saw the deceased alive on Jan 15, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wittard D. Meyers MD				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Jan 15, 1969	
22d. PHYSICIAN'S NAME (Type) Wittard D. Meyers MD				22e. ADDRESS 8323 Addison Drive Takoma Park Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-17-69		23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cem		23d. LOCATION (City or Town) (County) (State) Oxon Hill Md.			
24. FUNERAL DIRECTOR Ludwig Funeral Home 4217 9th St NW				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Charles D. Loggins			2a. DATE OF DEATH Month 1 Day 5 Year 67			2b. HOUR 1:30 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH December 27, 1910		6. AGE (in years last birthday) 58 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during last year, even if retired) Shoe Repair			12b. KIND OF BUSINESS OR INDUSTRY same	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. CITY OR TOWN Rockville		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER 1826 Muncaster Rd.			
14. FATHER'S NAME First Middle Last David Loggins			15. MOTHER'S MAIDEN NAME First Middle Last Cynthia (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO 577 20 5469		17. INFORMANT Beverly Loggins Address (Same as Above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>DSHO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 15, 1965</u> , to <u>Jan 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 5, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>George Sharpe</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>1/5-67</u>				
22d. PHYSICIAN'S NAME (Type) George Sharpe Md.						22e. ADDRESS Kensington, Maryland				
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 1/10/69		23c. NAME OF CEMETERY OR CREMATORY National Mem. Park		23d. LOCATION (City or Town) (County) (State) Falls Church Arl. Va.				
24. FUNERAL DIRECTOR Tyson Wheeler F. H. 1331 Rockville Pike Rockville, Maryland						25a. REC'D BY REGISTRAR Jan 14 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

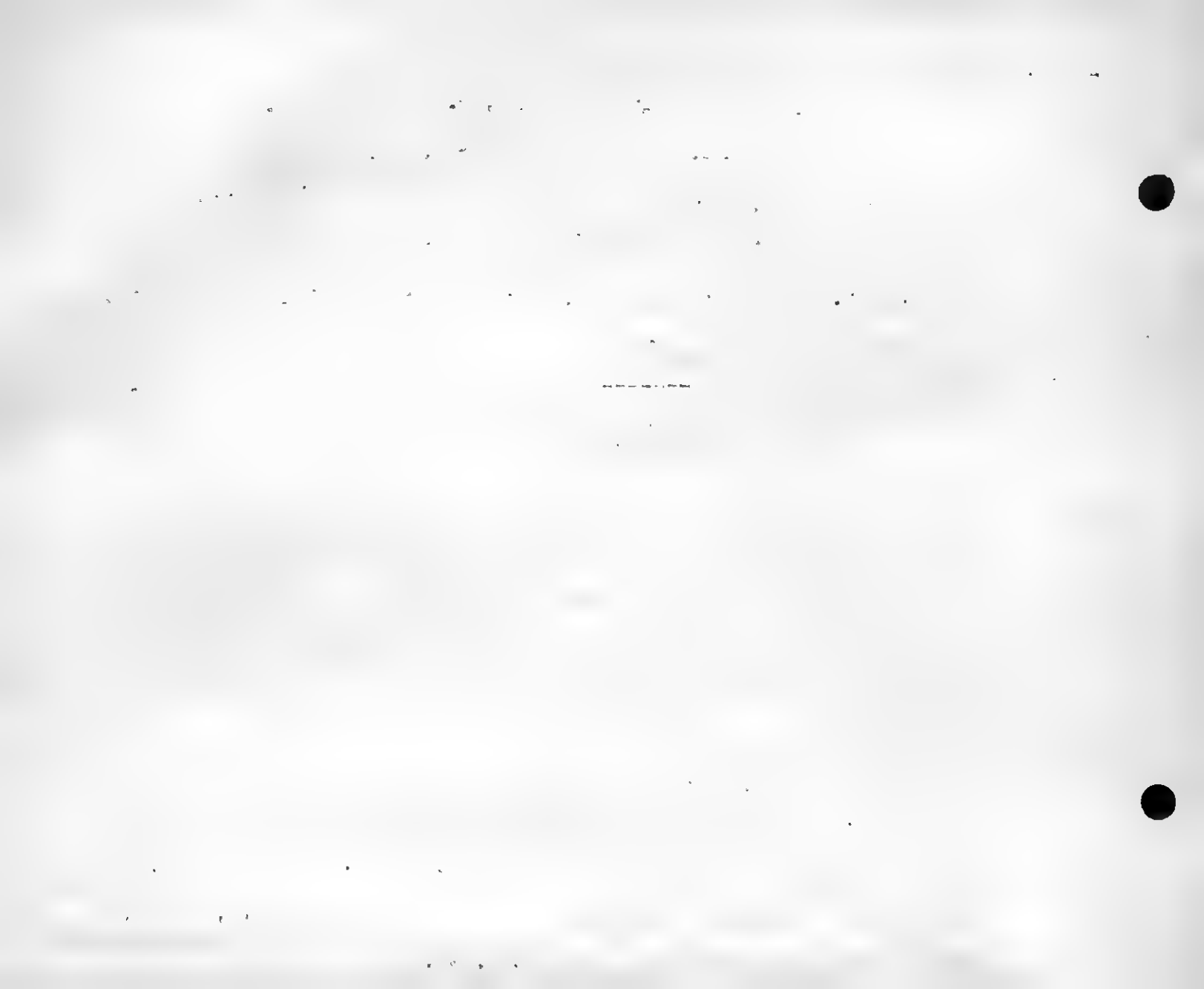
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 6 Film 409 1/29/69 kk										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Gregory Alan			Lohr, Jr.			Jan. 12 1969		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Male		White		Jan 12, 1969		YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		America				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
183 Md.			Montgomery		Rockville				163 Talbott St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Gregory Alan Lohr			Gloria Dean Dennis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
			-----		mother		as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hydrops fetalis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Seamus P. Nunan, M.D.								1-13-69.		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Seamus P. Nunan, M.D.			800 Pershing Dr. Silver Sp., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/17/69		Rockville		Rockville, Maryland				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler			1331 Rockville Pike, Rock. Md.			JAN 21 1969				



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0116

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <i>Charles Joseph Loy</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Jan. 6 1969			2b HOUR 6:15 M		
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>4-14-1906</i>	6 AGE (In years last birthday) <i>62</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>Jan</i> Day <i>6</i> Year <i>1969</i>		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a USUAL OCC. PAT OR Kind of work done during most of working life, even if retired <i>House Painter</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>RT-2</i>
14. FATHER'S NAME First <i>Robert</i> Middle <i>P</i> Last <i>Loy</i>			15 MOTHER'S MAIDEN NAME First <i>Helia</i> Middle <i>Boole</i> Last <i>Boole</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO (If yes give year or dates of service) <i>579-05-1827</i>		17. INFORMANT <i>Margaret Lopez</i>		ADDRESS <i>Same as above</i>		
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Injuries - severe</i> <i>814.7</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Trauma from being struck by Auto.</i> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>6:15 A.M. Jan 6 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Walked in front of oncoming car on Highway</i>				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) <i>Highway</i>		21f LOCATION Street or RFD No City or Town County State <i>70 E at Rockville. Rockville Mont. Md.</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John S. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>Jan. 6. 1969</i>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>1/9/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		23d LOCATION (City or Town) (County) (State) <i>Beallsville Mont. Md.</i>		
24 FUNERAL DIRECTOR <i>W.C. Hiltz</i>		ADDRESS <i>Barnesville Md.</i>		25a REC'D BY REGISTRAR DATE <i>JAN 10 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Julia Alberta Mahaney						Jan. 25 1969			2:30 P.M.
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Female	white		May 8, 1896			72 YRS.		8 17	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash., D.C.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			714 Sligo Avenue			Housewife		own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INS DE CITY, JIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Sil. Spr.			Apt. 107 714 Sligo Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
William A. Parker						Martha --			Hamilton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address		
no					yes		Michael J. Mahaney 714 Sligo Ave. Sil. Spr./Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4025 DUE TO, OR AS A CONSEQUENCE OF <u>HYPERTENSION ARTERIAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20 YRS.</u> (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3405.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES MELLITUS</u> <u>ANEMIA, SECONDARY</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>25 JAN. 1969</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>25 JAN. 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L.B. Snow M.D.</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>25 JAN. 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>L. B. Snow</u>						22e. ADDRESS <u>7950 New Hampshire Ave. Langley Pk. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)		
Burial			1-29-1969		Gate of Heaven Cemetery		Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>			ADDRESS <u>8434 Georgia Avenue</u>		25a. REG. NO. <u>30</u>		25b. REG. EXPIRATION DATE <u>1969</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Carl Alan Mangione			2a. DATE OF DEATH Month January Day 27 Year 1969			2b. HOUR 11:15 AM								
3 SEX Male		4 RACE White		5. DATE OF BIRTH 15 April 1961		6 AGE (In years last birthday) 7 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 11 MIN 15				
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md								
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Florida			13b. COUNTY Tampa			13c. CITY OR TOWN Tampa			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1919 East Idlewild Ave.		
14. FATHER'S NAME First Joseph Middle Mangione Last Massaro			15. MOTHER'S MAIDEN NAME First Joanna Middle Massaro Last Massaro											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO None			17 INFORMANT Bethesda, Maryland 20014 The Medical Records, The Clinical Center,								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gram negative shock 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Acute Lymphocytic Leukemia (b) DUE TO, OR AS A CONSEQUENCE OF (c) 5 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that XX (this hospital) attended the deceased from 22 Jan. , 19 69 , to 27 Jan. , 19 69 , that X (we) lost saw the deceased alive on 27 January 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death.														
22b. SIGNATURE Robert E. Gallagher, M.D. DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 27 January 1969						
22d. PHYSICIAN'S NAME (Type) Robert E. Gallagher, MD						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014								
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/28/1969		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) Tampa Florida						
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.						25a. REC'D BY REGISTRAR DATE 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

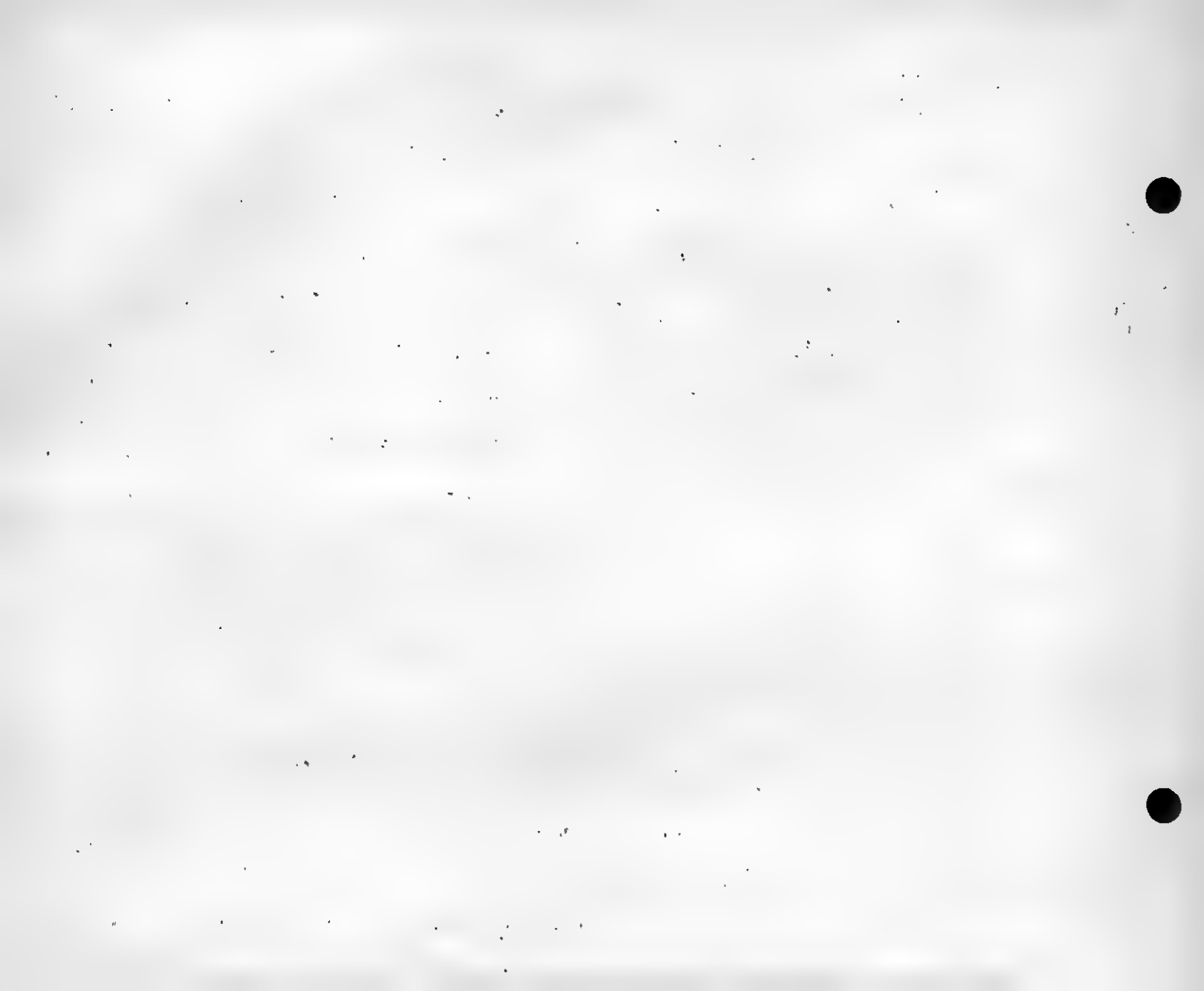
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME First BESSIE Middle DOLORES Last MANGO		2a DATE OF DEATH Month 1 Day 9 Year 69		2b HOUR 10 p M
3 SEX Female		4 RACE White		5. DATE OF BIRTH 4/3/85
6. AGE (In years last birthday) 83 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.		9. COUNTY OF DEATH montgomery Md
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none
13c. CITY OR TOWN Chillum		13d. INSIDE CITY LIM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 722 Rittenhouse St
14 FATHER'S NAME First Gaetano Middle mango Last mango		15 MOTHER'S MAIDEN NAME First ANNUNZIATA Middle MODARELLI Last MODARELLI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give year or dates of service)		16b. SOCIAL SECURITY NO 44-05-1395-D		17 INFORMANT Washington San & Hosp Records Address Takoma Park, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from Jan 58 to Jan 9, 1969 , that (I) (we) last saw the deceased alive on Jan 9, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE William D. Aude MD		22c. DATE SIGNED 1/9/69		
22d. PHYSICIAN'S NAME (Type) William D Aude MD		22e. ADDRESS 9006 Colesville Rd. Sil. Sp. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-13-69		23c. NAME OF CEMETERY OR CREMATORY FT. LINCLON CEMETERY
23d. LOCATION (City or Town) (County) (State) BLADENSBURG MARYLAND				
24 FUNERAL DIRECTOR 500 University Blvd N Silver Spring Md		25a. REG'D BY REGISTRAR JAN 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

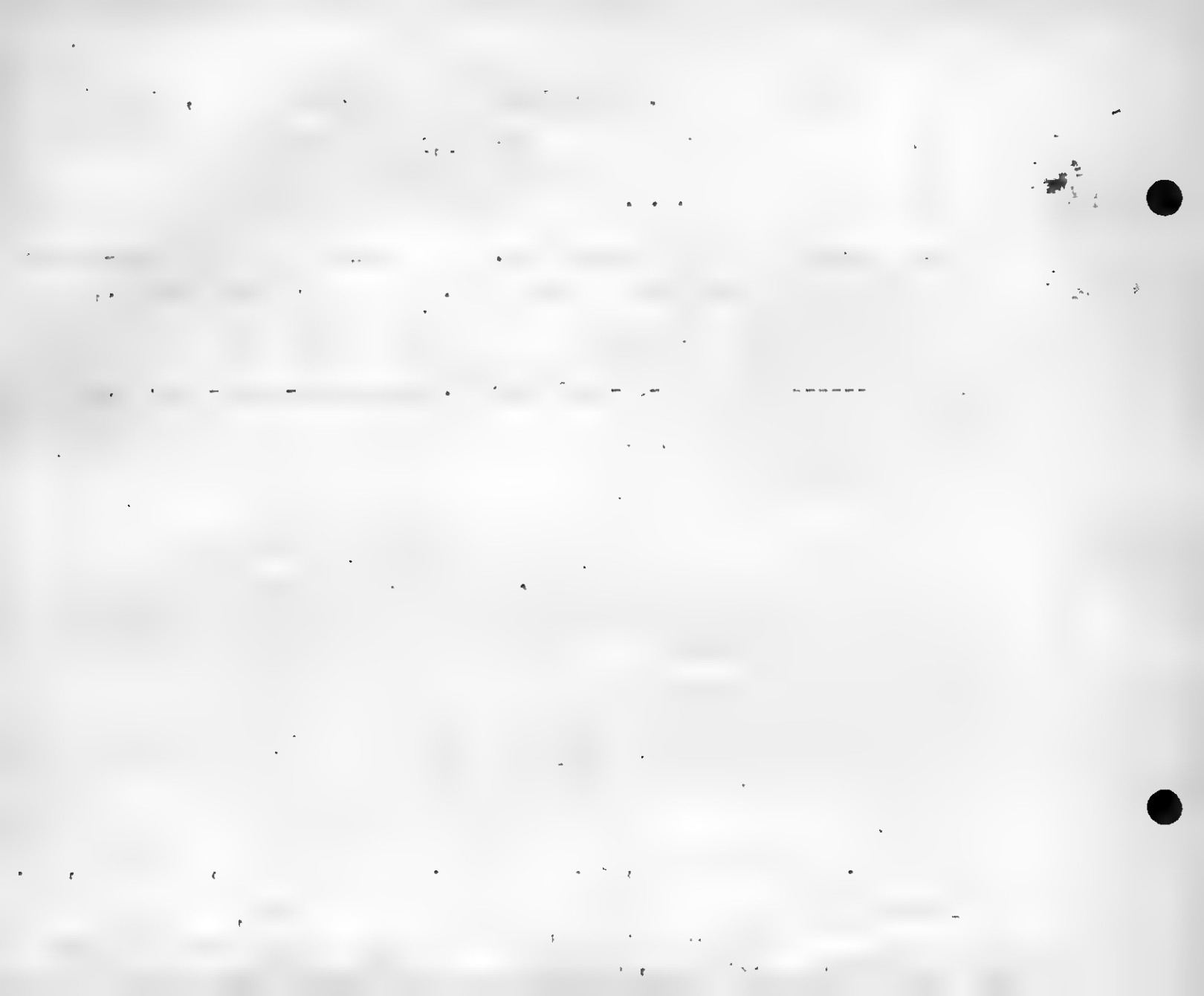


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

0116J		01161	
1. DECEASED NAME (Type or print) John		First Middle Last G. Manhollan	
2a. DATE OF DEATH January 31, 1969		2b. HOUR M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH June 1, 1913	
6 AGE (In years last birthday) 55 YRS.		7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery		Md	
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13519 Georgia Ave.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired	
12b KIND OF BUSINESS OR INDUSTRY Bus-Driver			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	13b. CITY OR TOWN Montgomery	13c. CITY OR TOWN Silver Spr.	13d. INSIDE CITY, HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e STREET AND NUMBER 13519 Georgia Ave.,			
14 FATHER'S NAME First Middle Last John William Manhollan		15. MOTHER'S MAIDEN NAME First Middle Last Mary Pitzer	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 293-05-5267	
17. INFORMANT Address Mary V. Manhollan - wife- same item # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 4/2 X DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Atherosclerotic heart disease			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 14, 1967 , to Jan. 29, 1969 , that (I) (we) last saw the deceased alive on Jan. 29, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE G. Bowditch Hunter, Jr.		22c. DATE SIGNED Jan. 31, 1969	
22d. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.		22e. ADDRESS 50 W. Edmonston Drive, Rockville, Md.	
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE 2/2/69	23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	
23d. LOCATION (City or Town) (County) (State) Poland, Ohio			
24. FUNERAL DIRECTOR Tyson Wheeler		25a. RECEIVED BY REGISTRAR FEB 3 1969	
25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

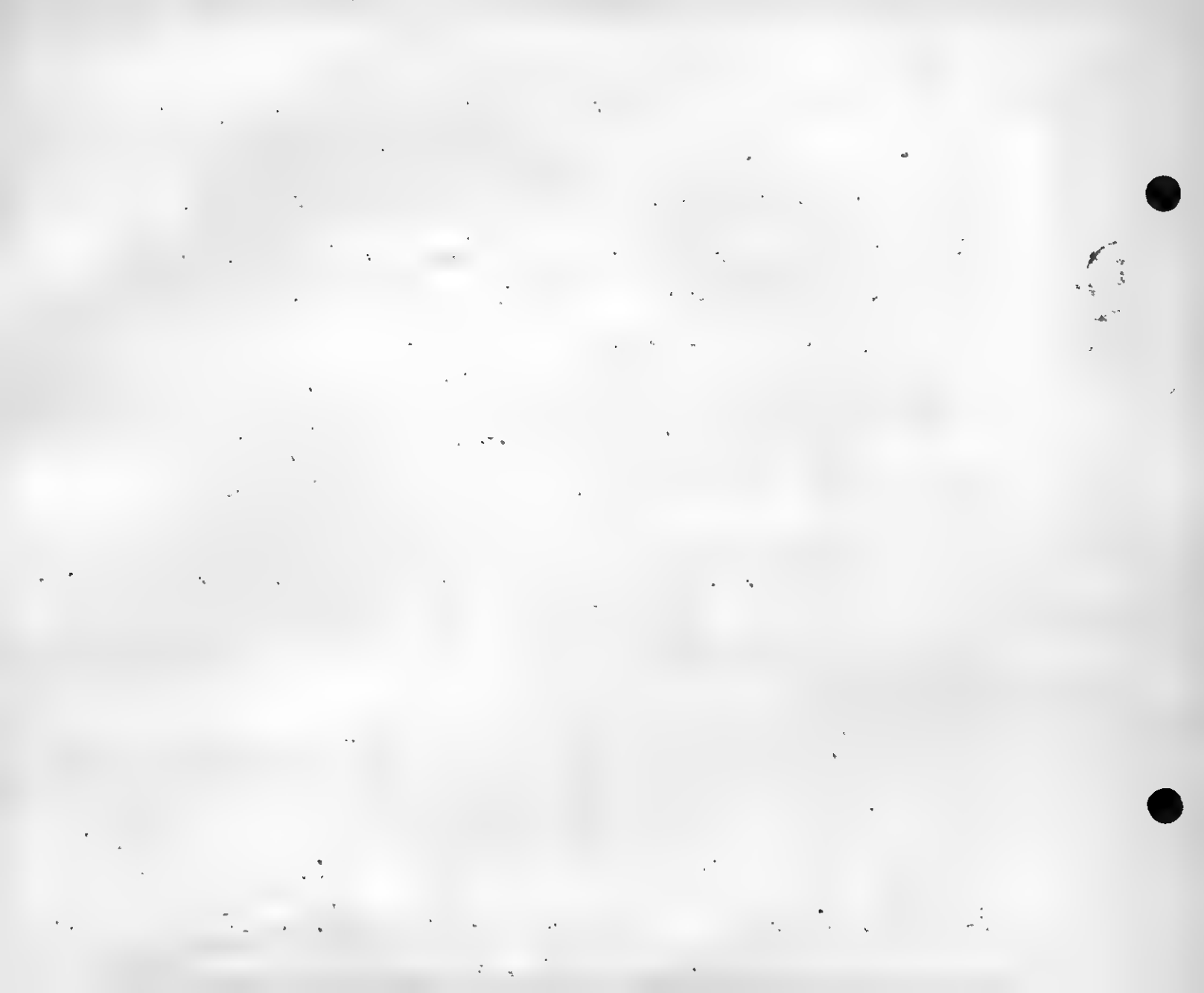
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0116.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1162

1. DECEASED NAME (Type or print) First Middle Last Alfred ERNEST MARLOWE			2a. DATE OF DEATH Month Day Year JANUARY 19 1969		2b. HOUR 15
3. SEX MALE	4. RACE CAUCASIAN		5. DATE OF BIRTH 8-15-10		6. AGE (In years last birthday) 58 YRS.
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? N. American		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Welder	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN D.C.	
13d. INSIDE CITY & MS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5604 14th St. N.W.			
14. FATHER'S NAME First Middle Last ERNEST MARLOWE			15. MOTHER'S MAIDEN NAME First Middle Last NANCY Henderson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 112-07-2249		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary emphysema & pulmonary Congestion					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALLOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1/19 , 19 65 , to 1/19 , 19 69 , that (I) (we) last saw the deceased alive on 1/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Samuel A. Hillman		22c. DATE SIGNED 1/19/69			
22d. PHYSICIAN'S NAME (Type) SAMUELA HILLMAN		22e. ADDRESS 8824 FLOWER AVE SILVER SPRING, MD. 20901			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-22-69		23c. NAME OF CEMETERY OR CREMATORY FT WINSTON CEM.	
23d. LOCATION (City or Town) DIADENSBURG		(County) MARYLAND		(State)	
24. FUNERAL DIRECTOR John W. Hillman					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01167

01163

1 DECEASED NAME (Type or print) Edwin F. Marques			2a DATE OF DEATH Jan. 18 1969			2b HOUR 4:30 A M				
3 SEX M		4 RACE CAUCASIAN		5. DATE OF BIRTH 10-3-1907		6 AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) Wash. DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.				
10 CITY OR TOWN OF DEATH Wheaton Md.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton H.H.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if instit. an. Residence before admission) STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Wheaton			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last James F. Marques			15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth S. Marques			13e STREET AND NUMBER 2600 WEISMAN Rd. Wheaton				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Congestive DUE TO, OR AS A CONSEQUENCE OF Kidney shutdown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infection, Diabetes DUE TO, OR AS A CONSEQUENCE OF Diabetes (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 days.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA - (Stroke)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year PM 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from Jan 1968 to Jan 1969 , that (I) (we) last saw the deceased alive on Jan 18 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE R. C. Bufalino						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED Jan 18, 69.		
22d PHYSICIAN'S NAME (Type) R. C. Bufalino, M.D.						22e ADDRESS 1429 University Blvd W.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 1/21/69		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR M. K. Himmelfarb						25a NEW BIRTH CERTIFICATE NO 1429		25b RECORDING CERTIFICATE NO 1429		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01168

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01164

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Mrs. Edythe L. Martin</u>			2a. DATE OF DEATH <u>JAN</u> Month <u>25</u> Day <u>1969</u> Year			2b. HOUR <u>12:35</u> PM								
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>1/3/97</u>		6. AGE (In years last birthday) <u>71</u> YRS.		IF UNDER 1 YEAR MONTHS <u>11</u> DAYS <u>23</u>		IF UNDER 24 MRS. HOURS <u></u> MIN <u></u>				
7a. BIRTHPLACE (State or foreign country) <u>Ohio</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <u>Mont. Co.</u> Md.					
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Holy Cross</u>			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Office</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>WAR Dept.</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Mont.</u>			13c. CITY OR TOWN <u>Bethesda</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <u>5003 Elsmere Ave.</u>		
14. FATHER'S NAME First <u>ISSIAC</u> Middle <u>H.</u> Last <u>MOORE</u>			15 MOTHER'S MAIDEN NAME First <u>MARGARET</u> Middle <u>HILL</u> Last <u>HILL</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <u>578-32-0851</u>			17 INFORMANT <u>MR. D.W. MARTIN</u> Address <u>5003-ELSMERE AVE. BETHESDA MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> <u>492X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>PULMONARY EMPHYSEMA & CHRONIC BRONCHITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATROPHY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS.</u>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>GOVEROR 1255 DETOR 1050000515 + MOLNUTRITION</u>				
19a. DATE OF OPERATION <u>—</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>66</u> , to <u>1/25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Charles E. Judge</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>1/25/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Harold S. Sterling</u>						22e. ADDRESS <u>1852 Union Blvd SE</u>								
23a. BURIAL CREMATION REMOVAL (Specify) <u>REMOVAL</u>			23b. DATE <u>1-29-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville Mont. Md.</u>					
24. FUNERAL DIRECTOR <u>Robert A. Phumpher</u>						ADDRESS <u>Bethesda Md.</u>			25a. REC'D BY REGISTRAR DATE <u>JAN 29 1969</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-14-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1165

01163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED <input type="checkbox"/>			Month Day Year			2b HOUR																																	
William Wright Martin						Jan. 25 1969			3:20 A																																				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR																														
Male		White		2-27-09		59 YRS						January 25 1969			3:20 A																														
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH																																	
West Virginia				United States								Montgomery Md																																	
10. CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b KIND OF BUSINESS OR INDUSTRY																											
Takoma Park						Washington San & Hospital						ENGINEER						CONSTRUCTION																											
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before death)						13b COUNTY						13c CITY OR TOWN						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e STREET AND NUMBER																					
Maryland						Prince George						Takoma Park						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						Prospect Avenue																					
14 FATHER'S NAME						15. MOTHER'S MAIDEN NAME																																							
Fred Martin						Byrl Wright																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO						17 INFORMANT						ADDRESS																											
No						231-16-8823 unknown						Tina Martin						10687 Weymouth St. Bethesda Md																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																											
PART 1 DEATH WAS CAUSED BY:																																													
IMMEDIATE CAUSE (a) Fractured skull with intracranial																																													
880X DUE TO, OR AS A CONSEQUENCE OF hemorrhage																																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																													
(b) DUE TO, OR AS A CONSEQUENCE OF																																													
(c)																																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																													
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 1-18 1969												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Deceased apparently fell down a flight of steps																					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>												21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home												21f. LOCATION Street or R.F.D. No City or Town County State Takoma Park P.G. Md.																					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																													
22a. I certify that I took charge of the remains described above, held on												Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																	
Actual Signature												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												22b. DATE SIGNED																					
EXAMINER'S NAME (Type)												Belden R. Neap												JAN. 25, 1969																					
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)									
Burial												1-27-69												Crest Hill												Tomb # 1									
24. FUNERAL DIRECTOR												ADDRESS												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE									
James J. Hall												414 N. 1st St. Baltimore, Md.												JAN 30 1969												James J. Hall									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

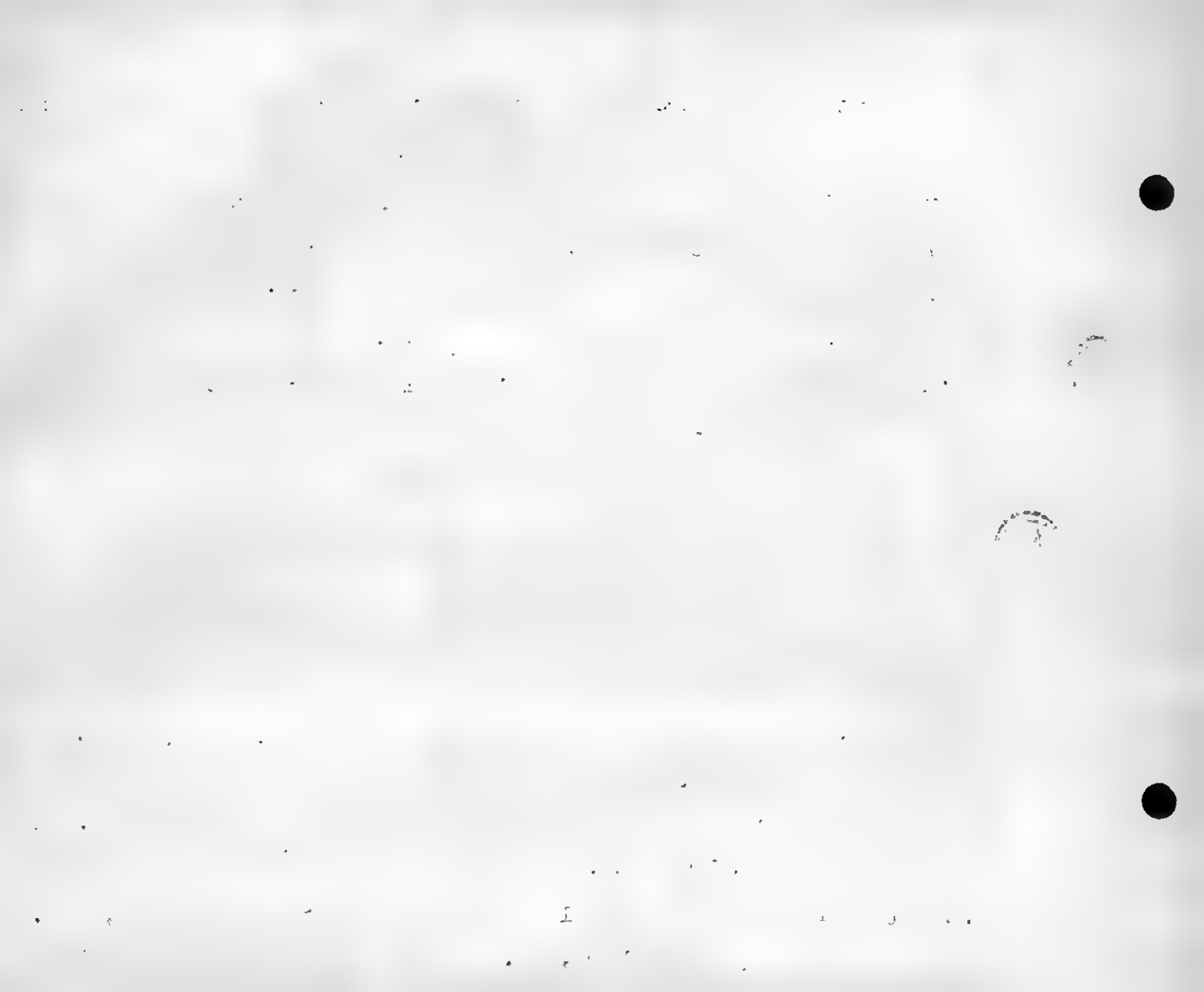
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last MAUDE H. Maxwell						2a. DATE OF DEATH Month Day Year Jan. 7 1969			2b. HOUR 11:30 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-5-93		6. AGE (In years lost birthday) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Co. - Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda - Silver Spring Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. U.S. JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Alabama		13b. COUNTY Tuscaloosa		13c. CITY OR TOWN North Port		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2101 18th St			
14. FATHER'S NAME First Middle Last Charles Holman				15. MOTHER'S MAIDEN NAME First Middle Last Fannie Shirley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give year or dates of service) *****		16b. SOCIAL SECURITY NO 419-10-2844-D		17. INFORMANT 4510 Arden Street, Bethesda, Md. Mr. Charles R. Maxwell					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Chromocytoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chromocytoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>Chromocytoma</u> (c) <u>Chromocytoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7.2 yrs.</u> <u>6 months</u> <u>2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10/19</u> , 19 <u>68</u> , to <u>1/7</u> , 19 <u>69</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>1/4</u> , 19 <u>69</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(not)</u> view the body after death.											
22b. SIGNATURE <u>George Sharpe</u>						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/7/69	
22d. PHYSICIAN'S NAME (Type) GEORGE SHARPE, M.D.						22e. ADDRESS 10400 Connecticut Ave. Kensington					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/8/69		23c. NAME OF CEMETERY OR CREMATORY Tuscaloosa Mem. Park		23d. LOCATION (City or Town) Tuscaloosa, Alabama		(County)		(State) Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.						25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Roy Chester McGlaughlin						January 19, 1969		10:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		12 May 1918		50 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pennsylvania		USA				Montgomery		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		The Clinical Center, NIH		Self-Employed		Tour guide				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Pennsylvania		1		Gettysburg				R.D. #3		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
Joseph McGlaughlin						Ruth Shultz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? Yes			16b. SOCIAL SECURITY NO. 1941-45			17. INFORMANT Bethesda, Maryland Address				
			Not Available			The Medical Records, The Clinical Center,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia								1 week		
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Chronic Myelogenous Leukemia								4 years		
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from 15 November 1968, to 19 Jan. 1969, that (we) (I) saw the deceased alive on 19 January 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
Sherrard L. Hayes, M.D.		20 January 1969		The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/22/1969		National Cemetery		Gettysburg, Adams, Pa.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Rene J. Monahan				Gettysburg, Pa.		JAN 23 1969		Charles Judge		



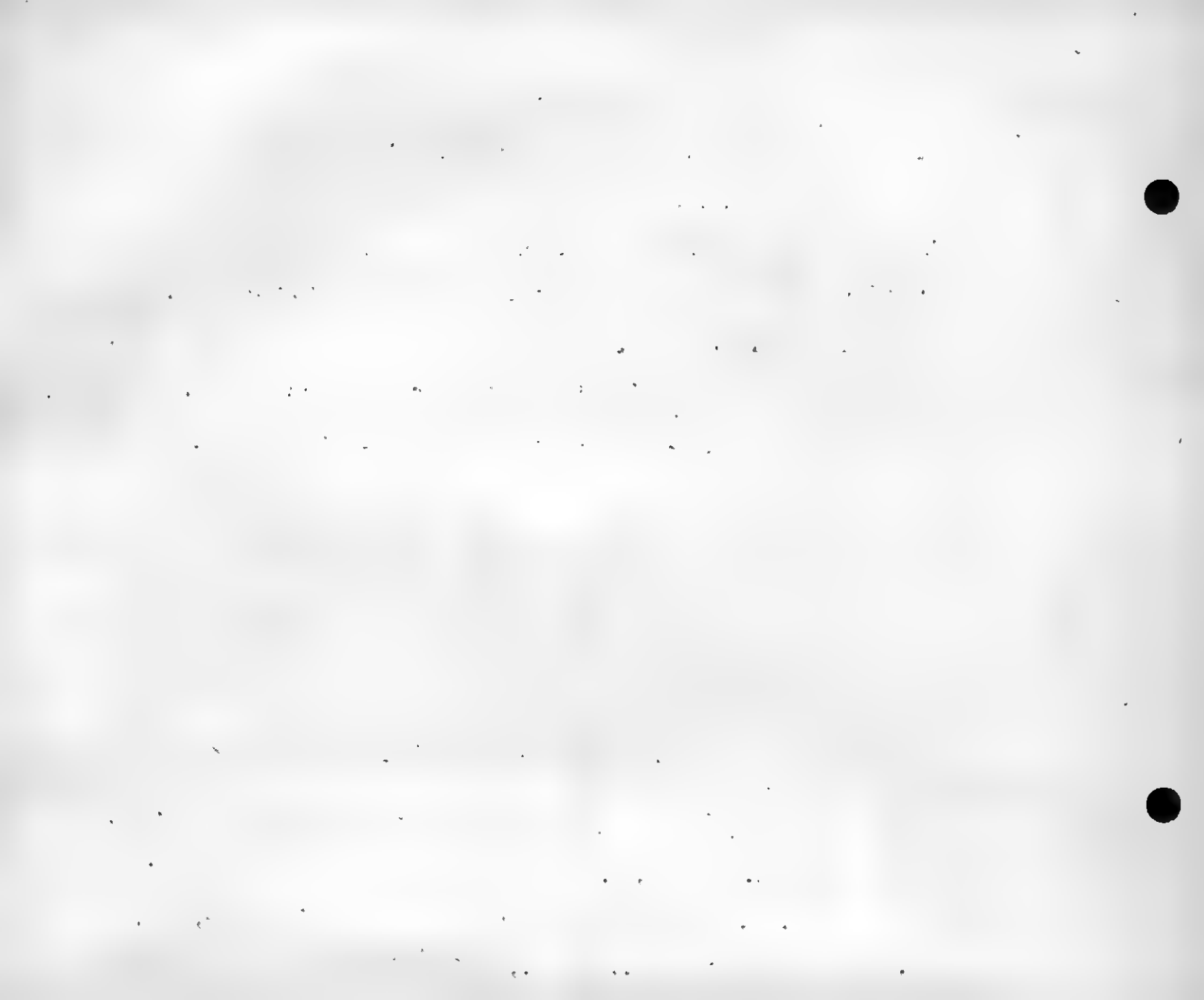
01172

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary			First Mary			Middle Ashe			Last Mersereau			2a. DATE OF DEATH Month 1 Day 12 Year 1969			2b. HOUR M		
3. SEX F			4. RACE W			5. DATE OF BIRTH Feb. 21, 1876			6. AGE (In years lost birthday) 91 YRS.			IF UNDER 1 YEAR MONTHS 11 DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) saleswoman			12b. KIND OF BUSINESS OR INDUSTRY Dept. store								
13a. USUAL RESIDENCE (Where deceased admission) Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 625 Melville Avenue					
14. FATHER'S NAME William			First Henry			Middle Ashe			15. MOTHER'S MAIDEN NAME Lucy			First Hayes			Middle Hughes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) No			16b. SOCIAL SECURITY NO. 215-10-6534-A			17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast - metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 8/13/63 19____, to 1/12/69 19____, that (I) (we) lost saw the deceased alive on 1/12/69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE Henry C. Scruggs, MD.			22c. DATE SIGNED 1/12/69			22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs, MD.			22e. ADDRESS 5413 Cedar Lane Bethesda Md.			22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 15, 1969			23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			23e. REG'D BY REGISTRAR JAN 14 1969					
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., Balto., 21229			ADDRESS			25a. REG'D BY REGISTRAR JAN 14 1969			25b. REGISTRAR'S SIGNATURE Charles J. Jones								

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CERTIFICATE OF DEATH

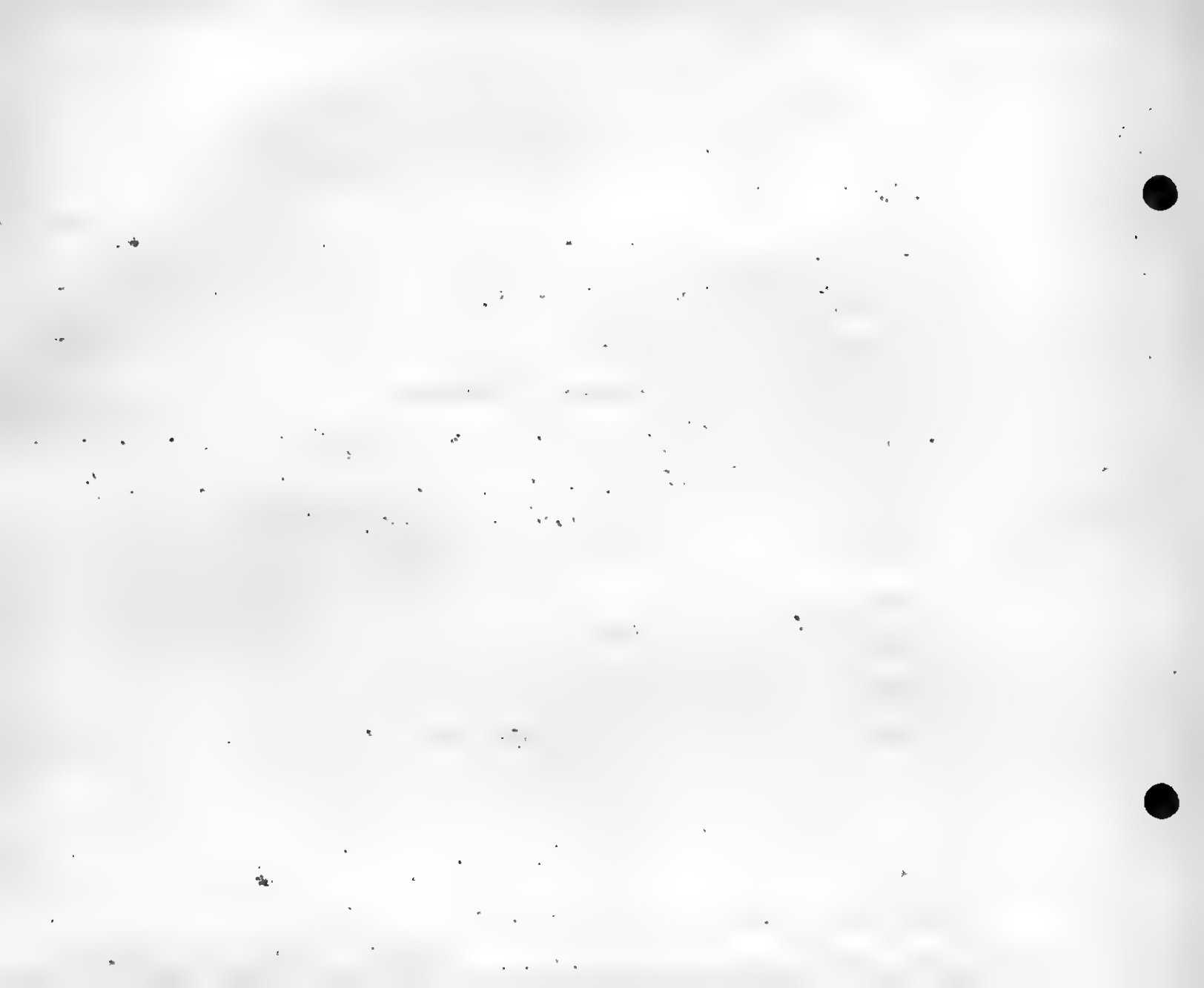
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01169

1 DECEASED-NAME (Type or print) JULIUS			First Middle Last METELITIS			2a DATE OF DEATH 01 Month 12 Day 69 Year 38			2b HOUR 11:30 AM		
3. SEX Male			4 RACE Cauc.			5 DATE OF BIRTH 2 1938 6/ / 195			6 AGE (in years last birthday) 26 YRS		
7a BIRTHPLACE (State or foreign country) D. C.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH SilverSpring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HolyCrossHosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b KIND OF BUSINESS OR INDUSTRY priv industry		
13a USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE Maryland			13b COUNTY Montg.			13c CITY OR TOWN SilverSp.			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 9317 Glenville Road			14 FATHER'S NAME First Middle Last Samuel Metelits			15. MOTHER'S MAIDEN NAME First Middle Last Esther Cohen					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW I			16b SOCIAL SECURITY NO. 577-07-2202			17 INFORMANT Alberta Metelits			Address Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm 441.2 DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertension DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION 1/12/69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BEARING AORTIC ANEURYSM			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1) or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/12/65 , to JAN 12 1969 , that (I) (we) last saw the deceased alive on JAN 12 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Albert H. Grollman						DEGREE MD			22c DATE SIGNED 1/12/69		
22d PHYSICIAN'S NAME (Type) ALBERT H. GROLLMAN MD						22e ADDRESS 1106 SILKING ST. SILVER SPRING					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-14-1969			23c. NAME OF CEMETERY OR CREMATORY National Memorial Park			23d LOCATION (City or Town) (County) (State) Falls Church Va.		
24. FUNERAL DIRECTOR Goldberg Funeral Home						ADDRESS 4217 9th St., N.W.			25a REC'D BY REGISTRAR DATE JAN 16 1969		
						25b REGISTRAR'S SIGNATURE Charles Judge					

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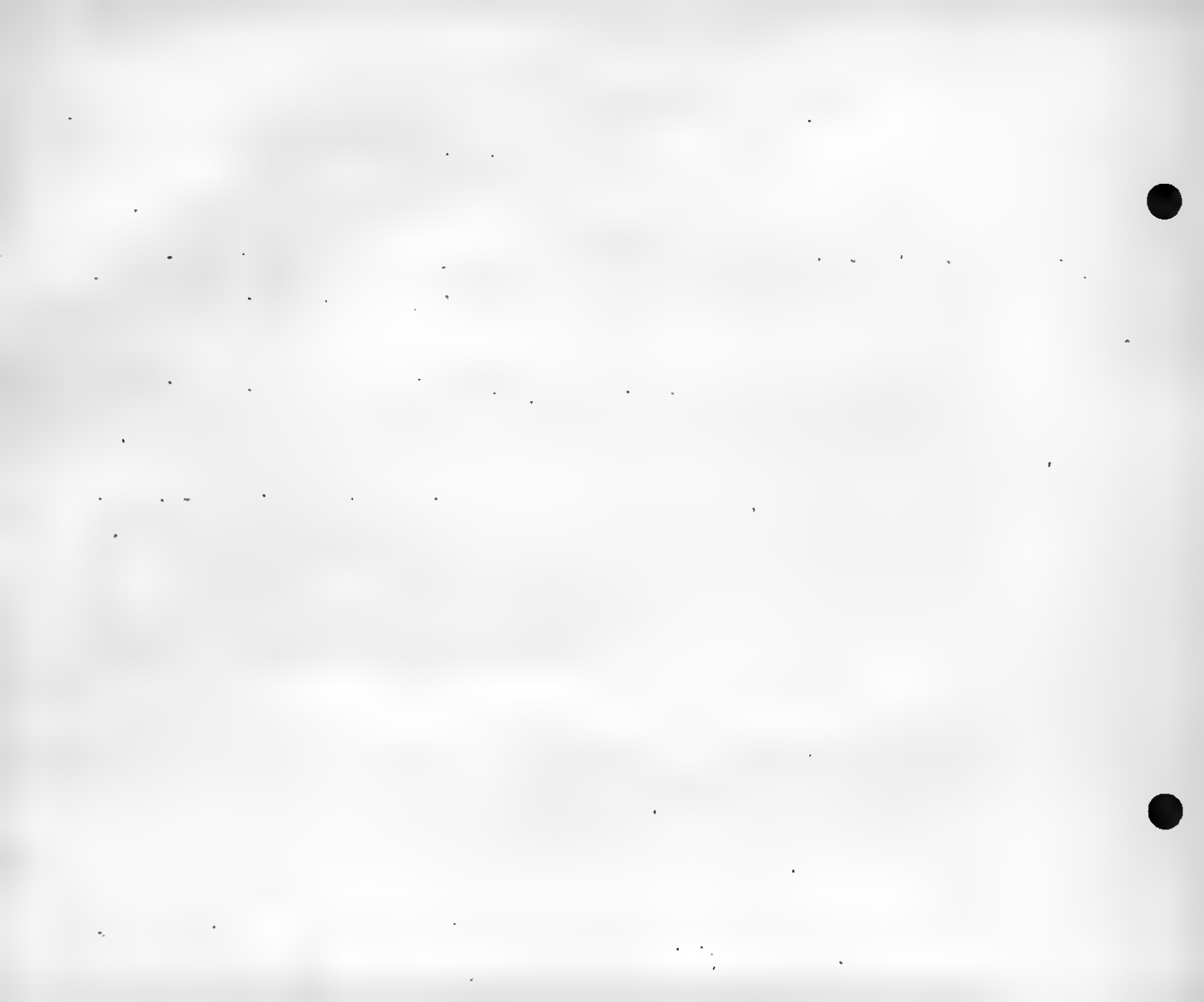
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VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

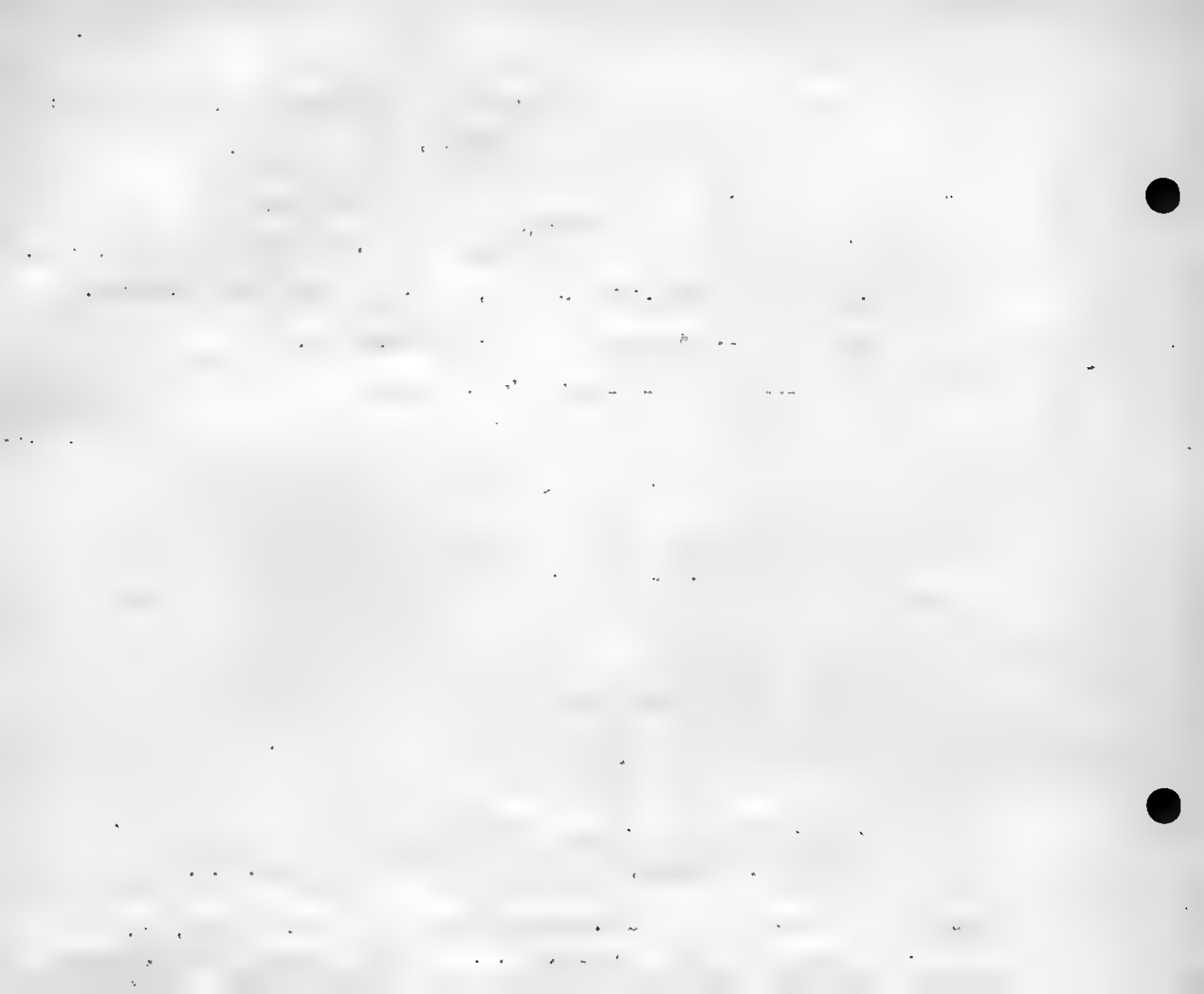
1 DECEASED NAME (Type or print) <i>First Peter A Middle Michael Last</i>		2a. DATE OF DEATH Month <i>4</i> Day <i>69</i> Year <i>1969</i>		2b HOUR <i>3:02 AM</i>	
3. SEX <i>M</i>	4 RACE <i>W</i>	5. DATE OF BIRTH <i>1-17-57</i>	6 AGE (In years last birthday) <i>11</i> YRS.	7 UNDER YEAR MONTHS <i>11</i>	8 UNDER 24 HRS DAYS HOURS MIN <i>11 11 11</i>
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HOLY CROSS HOSPITAL</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>CHILD-STUDENT</i>	12b KIND OF BUSINESS OR INDUSTRY <i>CHILD</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>	13b COUNTY <i>MONTGOMERY</i>	13c CITY OR TOWN <i>SILVER SPRING</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>3514 KAYSON STREET</i>	
14. FATHER'S NAME <i>First GEORGE Middle -- Last MICHAEL</i>	15. MOTHER'S MAIDEN NAME <i>First ATHENS Middle -- Last Dracopoulos</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>George Michael</i> Address <i>11400 Mt. Vernon, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>HEART FAILURE</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic pulmonary fibrosis + infection</i>				<i>8 yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cystic Fibrosis</i>				<i>8 yrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>HYPOPROTEINEMIA + MASSIVE EDEMA</i>					
19a. DATE OF OPERATION <i>NONE</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Birth</i> , 1957, to <i>1-4</i> , 1969, that (I) (we) lost saw the deceased alive on <i>1-4</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Stanley I. Wolf</i>		22c. DATE SIGNED <i>1-4-69</i>	22d. PHYSICIAN'S NAME (Type) <i>Stanley I. Wolf, MD</i>		
23a. BURIAL, CREMATION, REMOVAL <i>1-6-1969</i>		23b. DATE <i>1-6-1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>	
24. FUNERAL DIRECTOR <i>Lee</i>		25a. REC'D BY REGISTRAR <i>1 JAN 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
JACOB			MICKELSON			January 15th 1969			2:40 P M		
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			June 14, 1883			85 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Russia			USA						Montgomery Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Randolph Hills Nursing Home			Store Keeper			Genl. Mc. hd.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS. OF CITY LIMITS?		
Md.			Montgomery			Sil Spg.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Max			Mickelson			Mollie Baahaansky			228-18-4645		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Hosp. Records			Respiratory failure			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
20a. AUTOPSY?			21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
			<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either: nat'l medical examiner)			HOUR A.M. Month Day Year					
			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State		
			White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1969, to Jan 15, 1969, that (I) (we) last saw the deceased alive on Jan 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Robert L. Krichmar, MD			Jan 15 1969			7733 Alaska Ave. N.W.			Wash DC		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1-16-69			Natl. Memorial Park			Falls Church, Va		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REG. STAMP'S SIGNATURE			DATE		
Goldberg Funeral Home 4217 9th Street N.W.			JAN 17 1969			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

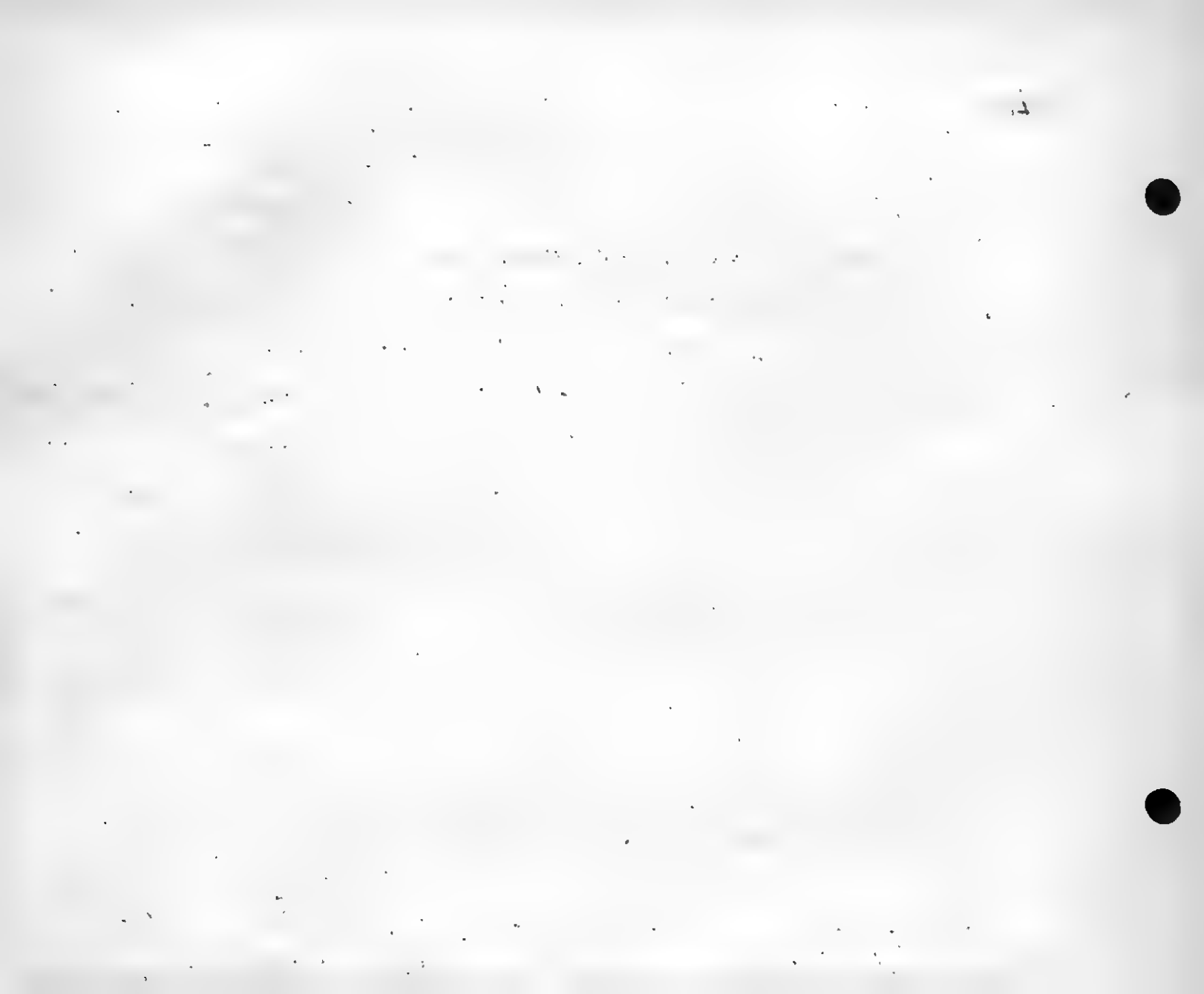
1 DECEASED NAME (Type or print) <i>Lillian</i>		First <i>REED</i>	Middle <i>MILLER</i>	2a DATE OF DEATH Month <i>Jan</i> Day <i>23</i> Year <i>1969</i>	2b HOUR <i>12:31</i> M
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>7/16/183</i>	6 AGE (In years last birthday) <i>85</i>	7c UNDER YEAR MONTHS <i>85</i> YEARS <i>85</i>	7d UNDER 24 HRS HOURS <i>12</i> MIN <i>31</i>
7a BIRTHPLACE (State or foreign country) <i>West Virginia</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give Street address) <i>Suburban Hospital</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12b KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>D.C.</i>	13b COUNTY <i>—</i>	13c CITY OR TOWN <i>D.C.</i>	3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>Rosslyn Hotel 16th + V St NW - Apt 101</i>	
14 FATHER'S NAME <i>Benjamin</i>	First <i>FRANKLIN</i>	Middle <i>REED</i>	15 MOTHER'S MAIDEN NAME <i>May</i>	First <i>VIRGINIA</i>	Middle <i>MOORE</i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	(If yes give war or dates of service)	16b SOCIAL SECURITY NO <i>577-34-7880</i>	17 INFORMANT <i>Son Reed Miller</i> Address <i>6006 Cromwell Wash D.C.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Right Cerebrovascular accident</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension + arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>unknown</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR AM <i>19</i> Month <i>Jan</i> Day <i>23</i> Year <i>1969</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.	21f LOCATION Street or RFD No	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from <i>15 Jan</i> , 1969, to <i>22 Jan</i> , 1969, that (I) (we) last saw the deceased alive on <i>22 Jan</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <i>Herbert Martin Jr MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED <i>23 Jan 69</i>
22d PHYSICIAN'S NAME (Type) <i>HERBERT MARTIN JR</i>	22e ADDRESS <i>4740 Chevy Chase Dr. Wash DC</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b DATE <i>1/25/69</i>	23c NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cem.</i>	23d LOCATION (City or Town)	(County)	(State) <i>Washington, D.C.</i>
24 FUNERAL DIRECTOR <i>JOS. GAWLER'S SONS, 5130 Wis. Ave. Wash, DC</i>	ADDRESS	25a REC'D BY REGISTRAR DATE <i>JAN 29 1969</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR
Gina Maria Montefusco						Jan. 17 1969			12:04 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	White	Sept. 10, 1968	4 YRS 7			January 17 1969			12:04 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Montgomery Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Child			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
New Jersey			V		E. Keansburg		YES		7 Wealthy Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John Montefusco			Dorothy Mundy						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT The Medical Record address				
No			None		The Clinical Center, NIH, Bethesda, Maryland				
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perforation of right ventricular myocardium/</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congenital Heart Disease, atrioventricular canal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mongolism</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 4 months 4 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <u>Jan. 17, 1969.</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Catheterization of Heart -</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR AM PM <u>1:13 P.M. Jan 17 1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Catheter: punctured heart wall -</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>N.H.</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Clinical Center NIH - Bethesda Montgomery Md.</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John G. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>Jan. 21, 1969.</u>			
EXAMINER'S NAME (Type) John G. Ball			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) Wash., D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-20-69		-		Keansburg, N. J.			
24. FUNERAL DIRECTOR W.W. Chambers Co., 1400 Chapin St., N.W. D.C.			ADDRESS Wash., D.C.			25a. REC'D BY REGISTRAR DATE JAN 27 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) Betty J. Morris			2a DATE OF DEATH Month January Day 11 Year 1969			2b HOUR 2:45 PM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH May 15, 1904		6 AGE (In years lost birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a BIRTHPLACE (State or foreign country) Mo.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.				
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 519 Orchard View	
14. FATHER'S NAME First Adebert Middle L. Last Jacobs			15. MOTHER'S MAIDEN NAME First Ettie Middle -- Last Nett							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No			16b SOCIAL SECURITY NO 220-54-1127		17 INFORMANT Dorothy Shapiro Address 519 Orchard View Sil. Spr. Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Status postoperative; carcinoma of vulva.										
19a DATE OF OPERATION NOV. 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of vulva				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from Nov. , 19 68 , to JAN. 11 , 19 69 , that (I) (we) last saw the deceased alive on JAN. 11 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Harold S. Fidler M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE-SIGNED JAN 12, 1969					
22d PHYSICIAN'S NAME (Type) Harold S. Fidler, M.D.					22e ADDRESS 9801 Georgia Avenue, Sil. Spr., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-14-1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery			23d LOCATION (City or Town) (County) (State) Pike, Georgia, Maryland			
24. FUNERAL DIRECTOR Glen Carter					ADDRESS Sil. Spr. Md		25a. REC'D BY REGISTRAR JAN 20 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 1 69
45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01176

1 DECEASED-NAME (Type or print) <i>Howard</i> First Middle Last <i>Morton</i>			2a DATE OF DEATH Month <i>Jan</i> Day <i>11</i> Year <i>1969</i>			2b HOUR <i>9:10</i> MIN	
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>7-2-00</i>		6 AGE (In years last birthday) <i>68</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Mont. Co.</i>		13c CITY OR TOWN <i>Cherry Chase</i>		13d INS DE CITY, JAN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <i>Eugene</i> Middle <i>Morton</i> Last <i>Morton</i>		15 MOTHER'S MAIDEN NAME First <i>Mabel</i> Middle <i>Knight</i> Last <i>Knight</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>no</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <i>179-10-6929</i>		17 INFORMANT <i>Hazel Morton</i> Address <i>Same as above</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i>							<i>immed.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>acute myocardial infarction</i>							<i>"</i>
(c) <i>arterio-sclerotic heart disease</i>							<i>6 yrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>arterio-sclerotic obliterations</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No City or Town County State			
22a I certify that (1) (this hospital) attended the deceased from <i>1962</i> , 19 <i>62</i> , to <i>Jan 11</i> , 19 <i>69</i> , that (1) (we) last saw the deceased alive on <i>Jan 9</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (a) (d) (did not) view the body after death.							
22b SIGNATURE <i>Wilfred R. Ehrmantraut MD</i>				22c DATE SIGNED <i>1/11/69</i>			
22d PHYSICIAN'S NAME (Type) <i>Wilfred R. Ehrmantraut</i>				22e ADDRESS <i>Rockville Md 20852</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>Jan 13, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Crematory</i>		23d LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md.</i>	
24 FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		24b ADDRESS <i>Hyattsville Md.</i>		25a REC'D BY REGISTRAR <i>JAN 14 1969</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0118

CERTIFICATE OF DEATH

01177

1 DECEASED NAME (Type or print) ^{First} Perry ^{Middle} Fielding ^{Last} Morton			2a DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>69</u>			2b HOUR <u>8:15 PM</u>	
3 SEX <u>male</u>		4 RACE <u>white</u>		5 DATE OF BIRTH <u>11/24/13</u>		6 AGE (In years last birthday) <u>55</u> YRS	
7a BIRTHPLACE (State or foreign country) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>	
10 CITY OR TOWN OF DEATH <u>Rockville</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>4423 Hallett St.</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Meat cutter-Grand Union</u>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if instituton: Residence before admission) STATE <u>Maryland</u>		13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Rockville</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <u>4423 Hallett St.</u>							
14 FATHER'S NAME ^{First} <u>Fielding</u> ^{Middle} <u>Luther</u> ^{Last} <u>Morton</u>				15 MOTHER'S MAIDEN NAME ^{First} <u>Grace</u> ^{Middle} <u>Ellen</u> ^{Last} <u>Perry</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16b SOCIAL SECURITY NO. <u>402-09-0697</u>		17 INFORMANT Address <u>John Morton same as above</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Sarcomatosis & Cachectia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leiomyosarcoma of the Stomach</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8 month</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 month</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <u>August 1968</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Leiomyosarcoma</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>68</u> , to <u>Jan 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. Neill Kennedy MD</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/10/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>J. Neill Kennedy</u>				22e. ADDRESS <u>916-19th St. N.W., Wash, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/14/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md</u>	
24. FUNERAL DIRECTOR <u>The S.H.Hines Company</u>				ADDRESS <u>Washington DC</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 14 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			2b HOUR
John David Moten						EST MATED Jan 4 1969			25 M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD	2d HOUR
M.	Negro	May 8, 1875	93 YRS					Jan 4 1969	25 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville.			312 Lincoln Ave.			Butcher		Blacksmith.	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery		Rockville			312 Lincoln Ave.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
Phillip Moten			Annie Fields.						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
NO					MRS ANNA JACKSON 312 Lincoln ave, ROCKVILLE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute									
4123 DUE TO, OR AS A CONSEQUENCE OF Cardio Vascular Disease								years.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Diabetes Melitus.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Jan 4, 1969			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL			1-8-69		FISHERMAN, S. CEMETERY		ROCKVILLE, MONTG. MD		
24 FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE
Robert L. Snowden					ROCKVILLE, MD		JAN 10 1969		Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01183

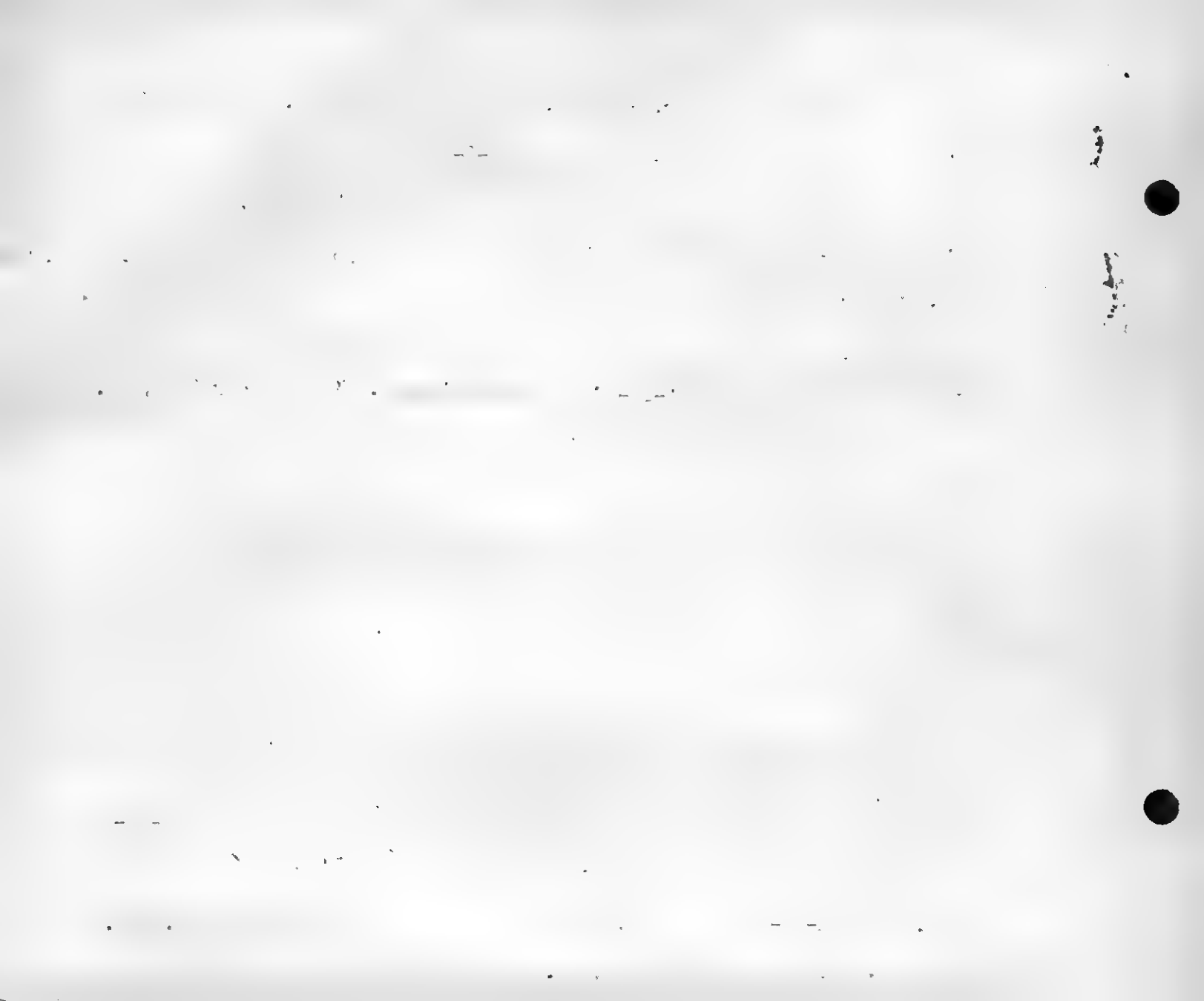
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01179

Item #11, Film GL09 1/31/69 km CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Howard Hedges Mull			2a DATE OF DEATH Jan. Month 17 Day 1969 Year 1969		2b. HOUR 12 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-3-1906		6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Rural Derwood	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 17910 Bowie Mill Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tailor	12b. KIND OF BUSINESS OR INDUSTRY Clothing Ind.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Derwood	13d. INSIDE CITY LIM TSP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 17910 Bowie Mill Rd.	
14 FATHER'S NAME First Middle Last George Mull	15. MOTHER'S MAIDEN NAME First Middle Last Garcie Jane Hoff				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown] (If yes give war or dates of service) no	16b. SOCIAL SECURITY NO. 214-10-4770	17 INFORMANT Address Jacqueline J. Wines Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 62 , to 1/11 , 19 69 , that (I) (we) last saw the deceased alive on 1/11 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. L. Neal M.D.	22c. DATE SIGNED 1-17-69	22d. PHYSICIAN'S NAME (Type) Lucian O. Leal			
22e. ADDRESS Gaithersburg, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-21-69	23c. NAME OF CEMETERY OR CREMATORY St. Lukes	23d. LOCATION (City or Town) (County) (State) Redland, Mont. Md.		
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Laytonsville, Md. 20760		25. REGISTRAR'S SIGNATURE JAN 22 1969		



0118

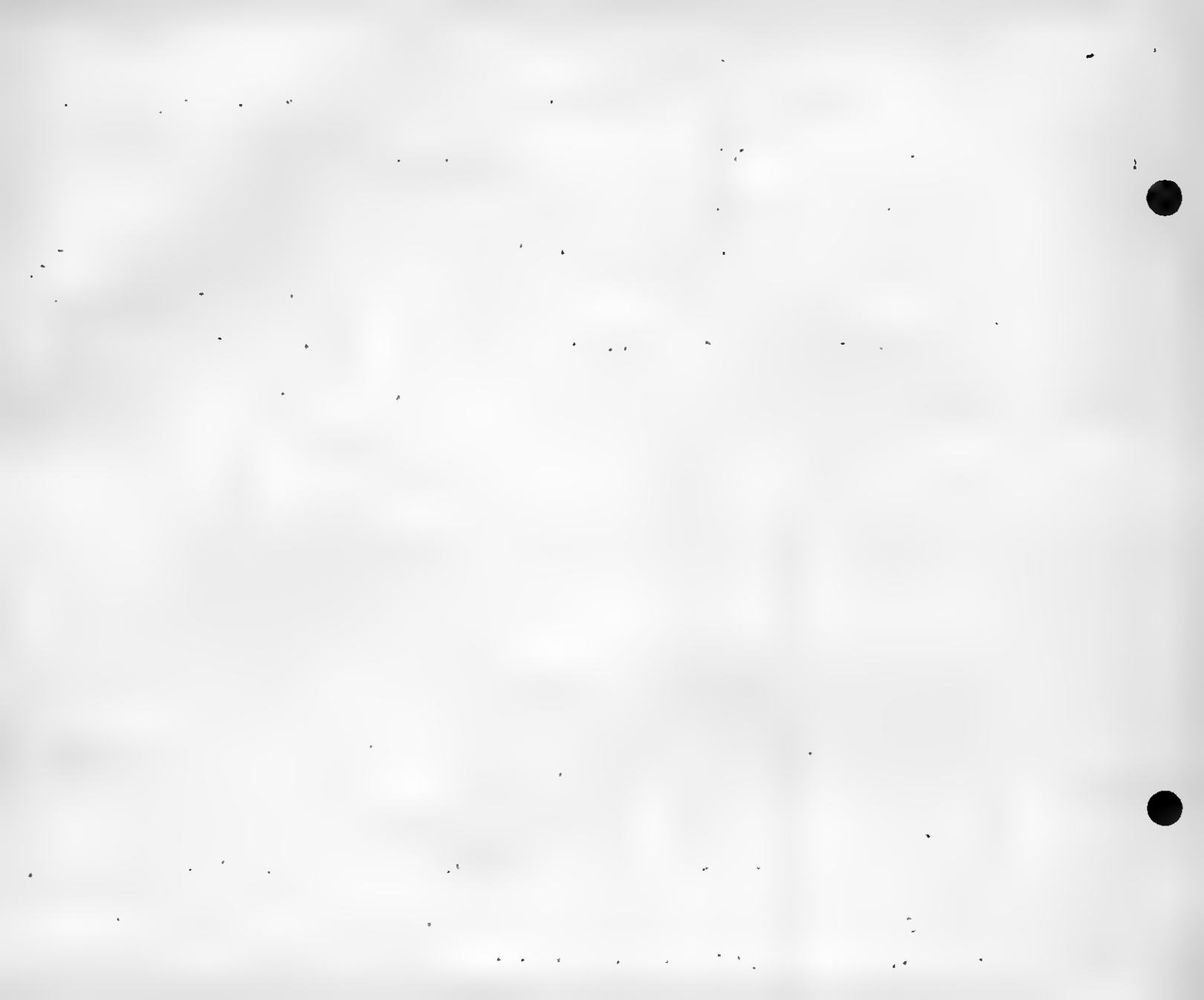
01180

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Baby Girl Mulligan			2a. DATE OF DEATH Month January Day 30 , Year 1969			2b. HOUR p 5:09	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 30, 1969		6. AGE (In years lost birthday) YRS. MONTHS DAYS HRS. MIN. 20	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10111 McKenney Ave., Apt. 201		14. FATHER'S NAME First Patrick Middle William Last Mulligan		15. MOTHER'S MAIDEN NAME First Mary Middle Carol Last Reinecke			
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16b. SOCIAL SECURITY NO None		17. INFORMANT Mother, Same as #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive atelectasis both lungs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-30, 1969 , to 1-30, 1969 , that (I) (we) last saw the deceased alive on 1-30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Louis H. Moody, Jr., M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-31-69	
22d. PHYSICIAN'S NAME (Type) LOUIS H. MOODY				22e. ADDRESS 8641 Colesville Rd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/3/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, 5130 Wis. Ave., Wash., D.C.				25a. REC'D BY REGISTRAR DATE FEE 6 1969		25b. REGISTERAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral
director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

J1182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9600 Forest Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9600 Forest Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SISTER - ALOYSIUS MURPHY</u> First Middle Last		4. DATE OF DEATH <u>Jan. 9, 1969</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 24 1884</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <u>84 yrs.</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nun - Catholic Sister</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N. Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Patrick Murphy</u> 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Jennings</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Marguerite Irwin</u> Address <u>Same as Item 2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> (c) <u>ARTERIO SCLEROSIS, GEN'L</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1-hr</u> <u>5+YRS</u> <u>10+YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CANCER (R) BREAST WITH METASTASIS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D.A.A.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> 19 to <u>present</u> , that (I) (we) last saw the deceased alive on <u>11/8</u> 1969 , and that death occurred at <u>2:5</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles Savarese, MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/9/69</u>			
22c. PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE, MD</u>		22d. ADDRESS <u>11125 ROCKVILLE PIKE ROCKVILLE MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-11 -69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			
23d. LOCATION (City, town or county) <u>Washington, D. C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					
25a. REC'D BY: REGISTRAR <u>JAN 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



Cleared by Dr. B. B. Reap

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-222a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07102

31180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year				2b. HOUR	
ANNA			L.	Nelson		1 2 1969				11:25	
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Female	White	8/12/89	79 YRS					1 2 19 69		11:25	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Stockholm Sweden			USA		Montgomery				Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			housewife			own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery			Silver Spring				1008 Nicholas Dr. SSnd.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Johann Ljungberg						Marie					(Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
none			Yes			daughter Arlene M Cocita			11008 Nocholas Dr. SSnd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Massive bilateral											
450X DUE TO, OR AS A CONSEQUENCE OF											
pulmonary embolus											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				JAN. 2, 1969			
Belden R. Reap M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ADDRESS				ADDRESS (Street, City or Town, County)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		1-4-1969		George Washington Cemetery			Hyattsville Pr. Georg. Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C. Glen Carter		Sil. Spr. Md.		JAN 9 1969		Nicholas Judge					
Garner E. Pumphrey, Inc. 8434 Georgia Avenue											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
JOHN			EARL			NELSON			January 7 1969 1:00 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		NEGRO		12-25-1886		82 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
md		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
MARTINSBURG			Elmer School Road			RETIRED			NONE
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MD			MONTG.						ELMER SCHOOL ROAD
14. FATHER'S NAME			15. MOTHER'S M.A.D.E.N. NAME						
First Middle Last			First Middle Last						
UNKNOWN			IRENE			HALLMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Osteoarthritis, Severe; Prostatic Hypertrophy; Malnutrition</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>24 Dec 1968</u> , to <u>7 Jan 1969</u> , that (I) (we) lost saw the deceased alive on <u>24 Dec 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Gordon Murdoch Smith, MD</u>			DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4 Jan 69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Gordon Murdoch Smith</u>			22e. ADDRESS <u>Barnesville, Md. 20703</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			1-6-69		WARREN CHAPEL CEMETERY		MARTINSBURG, MONTG. MD		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
ROBERT L. SNOWDEN			ROCKVILLE, MD			JAN 8 1969		<u>William Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
01186		01184											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH			2b HOUR	
DOROTHY			ANN		NEWMAN		JAN 23 69			6:15 PM			
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 48 HRS		
FEMALE		CAUS.		1/15/1903			66 YRS		MONTHS		DAYS		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.					
WASH. DC		USA				Montgomery							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
WASH. DC			UNIVERSITY NURSING HOME			HOUSEWIFE			own home				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
WASH. DC			--		D. C.				1653 NEWTON ST. N.W.				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
William J. Mullin			Blanche A. Hazel										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT								
			577-56-0818		Burnell N. Newman 1653 Newton Street, N.W.								
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>respiratory arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>subdural hematoma</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ventricularricular insufficiency</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>													
MEDICAL CERTIFICATION													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State									
22a I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>68</u> , to <u>1/23</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED											
David Morowitz, M.D.		1/23/69											
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS											
David Morowitz, M.D.		Wheaton, Maryland											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)							
Burial		1-27-1969		Gate of Heaven Cemetery		Silver Spring Montgomery Md.							
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
C. Glen Carter		JAN 29 1969		Charles Judge									
Warner E. Pumphrey, Inc. 8434 Georgia Avenue													

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) James Edgar Newton			2a. DATE OF DEATH Month 1 Day 29 Year 69			2b. HOUR 12⁵³ P M	
3. SEX male		4. RACE white		5. DATE OF BIRTH 10-25-1894		6. AGE (in years lost birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Sanitarium - Borist		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Electrician - Gov't		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1224 Dale Drive		14. FATHER'S NAME First Henry Middle Clay Last Newton		15. MOTHER'S MAIDEN NAME First Martina Middle -- Last Frazier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. Under 18		17. INFORMANT Olga A. Newton 1224 Dale Drive, Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Massive hemorrhage on the left							
DUE TO, OR AS A CONSEQUENCE OF (b) Perforation of a large atherosclerotic							
DUE TO, OR AS A CONSEQUENCE OF (c) aneurysm of thoracic aorta							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) Severe nephrosclerosis - Severity							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 22, 1969 , to Jan 29, 1969 , that (I) (we) lost the deceased alive on Jan 29, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip E. Jones, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-29-69	
22d. PHYSICIAN'S NAME (Type) Philip E. Jones		22e. ADDRESS 800 Pershing Drive Silver Spring, Md. 20910					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 2-1-1969		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		C. Glen Carter Address Silver Spr. Md.		25a. REGISTERED REGISTRAR FFR 5 1010		25b. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Eulalia M. Nichols</i>						2a. DATE OF DEATH Month Day Year <i>1 31 69</i>			2b. HOUR <i>9A</i>		
3. SEX <i>FEMALE</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11-28-93</i>			6. AGE (In years lost birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>PA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County, Md.</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>804 DALEVIEW DRIVE</i>	
14. FATHER'S NAME First Middle Last <i>Francis Miller</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Sarah Scattergood</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO <i>400-12-3377D</i>		17. INFORMANT <i>Dorothy M. Bradshaw</i>				Address <i>Same as #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Basal cell carcinoma of skin of nose.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-25, 1969</i> , to <i>1-31, 1969</i> , that (I) (we) last saw the deceased alive on <i>1-31, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bernard A. Fitzgerald</i>						DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-31-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>						22e. ADDRESS <i>217 UNIV. BLVD E, SILVER SPRING MCD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-3-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Dominic</i>		23d. LOCATION (City or Town) (County) (State) <i>Philadelphia Pa.</i>					
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>						ADDRESS <i>500 University Blvd W Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

10/10/10

5/1



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classified by Medical Examiner - M.A. 68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last MARY TO NIEFELD			2a. DATE OF DEATH Month Day Year JANUARY 5 1969			2b. HOUR 5:00 P.M.					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH APRIL 16, 1888		6. AGE (In years lost birthday) 80 YRS.		7. UNDER YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMARY			Md.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMARY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1018 DEVERE DRIVE			
14. FATHER'S NAME First Middle Last ALEC TASH			15. MOTHER'S MAIDEN NAME First Middle Last RIVA KATZ								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 59-44-9500			17. INFORMANT MRS. GOLDIE FREEDMAN			Address (Same as 13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure. 41.5 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Disease - Aortic valve disease.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 6-1966, to 1-5-1967, that (I) (we) lost saw the deceased alive on 1-5-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Morton Altschuler						DEGREE MED. DIRECTOR		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-5-69	
22d. PHYSICIAN'S NAME (Type) Morton Altschuler						22e. ADDRESS 2205 N. Hampshire Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE 1-7-1969		23c. NAME OF CEMETERY OR CREMATORY G.W. CEMETERY		23d. LOCATION (City or Town) HYATTSVILLE, MD.		(County)		(State)	
24. FUNERAL DIRECTOR Goldberg Funeral Home						ADDRESS 4217-94th Ave. NW		25a. REG'D BY REGISTRAR JAN 5 1969		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11769 Cleared with Dr. B. R. Rappaport

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
0119																	
CERTIFICATE OF DEATH																	
01188																	
1. DECEASED NAME (Type or print) <i>James</i>			First <i>Taylor</i>			Middle <i>Noble</i>			Last <i>Noble</i>			2a. DATE OF DEATH Month <i>January</i> Day <i>1</i> Year <i>1969</i>			2b. HOUR <i>1:35</i> M		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>August 15, 1913</i>			6. AGE (In years last birthday) <i>55</i> YRS.			7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN			8. IF UNDER 24 HRS HOURS <i>0</i> MIN		
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>West Chester</i>			Md					
10. CITY OR TOWN OF DEATH <i>West Chester</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Friendship Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Penn.</i>			13b. CITY OR TOWN <i>West Chester</i>			13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <i>11 W. Chestnut Street</i>								
14. FATHER'S NAME First <i>Lowndes</i> Middle <i>James</i> Last <i>Taylor</i>			15. MOTHER'S MAIDEN NAME First <i>Armenia</i> Middle <i>FLORENCE</i> Last <i>Yoric</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO. <i>179-36-5281</i>			17. INFORMANT <i>Harold A. Famous</i>			Address <i>West Chester, Penn.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i>												<i>Undetermined</i>					
4123 DUE TO, OR AS A CONSEQUENCE OF <i>Generalized Arterio-sclerosis</i>												<i>Undetermined</i>					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <i>Cerebro-sclerosis</i>												<i>Undetermined</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Fractured Left hip (old) Sept 18, 1968</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 15, 1967</i> to <i>Jan 1, 1969</i> , that (I) (we) lost saw the deceased alive on <i>Dec 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d-d) (did not) view the body after death.																	
22b. SIGNATURE <i>George L. Ball</i>			DEGREE <i>MD</i>			ATTENDING PHYS <input checked="" type="checkbox"/> MED D RECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>Jan 1, 1969</i>								
22d. PHYSICIAN'S NAME (Type) <i>George L. Ball</i>			22e. ADDRESS <i>10620 Georgia Ave Silver Spring Md 20902</i>														
23a. BURIAL CREMAT. REMOVAL <i>bury</i>			23b. DATE <i>1-3-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale Ave. Friends Burial Grounds</i>			23d. LOCATION (City or Town) (County) (State) <i>West Chester, Penn.</i>								
24. FUNERAL DIRECTOR <i>J.W. Lee</i>			ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>			25a. REC'D BY REGISTRAR <i>JAN 6 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
James Joseph O'Connor						ESTIMATED <input checked="" type="checkbox"/> Jan. 22 1967			12 25 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
M	WHITE	12-05-07	61 YRS	MONTHS	DAYS	HOURS	MIN.	Month 12 Day 22 Year 1967			1 03 PM
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New York		USA				Montgomery Md					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban								
13a USJA. RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY, IN 157		13e STREET AND NUMBER	
New York			Onondaga Syracuse			YES <input type="checkbox"/> NO <input type="checkbox"/>				129 Oakdale Dr.	
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Timothy Francis O'Connor				Mary Griffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS			
yes			074-09-3445		Wife E. Loise O'Connor.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage, Massive Gastrointestinal										24 hr.	
5000 DUE TO, OR AS A CONSEQUENCE OF										Months 2	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Duodenal Ulcers, Multiple											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			Hour A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			John G. Ball			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Jan. 22, 1967.		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town or county)					
23a BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1-27-69		St. Mary's Cemetery		Dewitt				New York	
24 FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS						25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
7557-Wisconsin Ave., Bethesda, Md.						DATE JAN 28 1969		[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01192										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01190																			
1 DECEASED NAME (Type or print)										First Middle Last										2a. DATE OF DEATH																			
Lloyd										Odend'hal										Month Day Year 31 1969 11:30 PM																			
3 SEX					4 RACE					5. DATE OF BIRTH					6 AGE (n years last birthday)					IF UNDER YEAR MONTHS					IF UNDER 24 HRS HOURS MIN														
Male					Caucasian					3-6-1883					85 yrs																								
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH																								
Maryland					United States										Montgomery Md																								
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY									
Kensington										3114 University Blvd. West										Attorney - retired										Law									
13a. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) STATE										13b. COUNTY					13c. CITY OR TOWN					3d. INS DE CTY, UNITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER														
Maryland										Montgomery					Kensington										3114 University Blvd. West														
14 FATHER'S NAME First Middle Last										15 MOTHER'S M maiden name First Middle Last																													
Lucien										Clande										Cornelia Grant																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no										16b. SOCIAL SECURITY NO					17 INFORMANT Address																								
										215-50-3362-1					Mrs. Evelyn W. Odend'hal, same as #13																								
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100										myocardial infarction										sudden																			
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis, gen'l & coronary																				30 yrs																			
DUE TO, OR AS A CONSEQUENCE OF (c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1 (c)																																							
nephrosclerosis, Rheumatoid arthritis																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.										21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Mar. 1967, to Jan. 31, 1969, that (I) (we) last saw the deceased alive on Jan. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										22c. DATE SIGNED																													
Philip H. Varner, M.D.										Jan. 31, 1969																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
Philip H. Varner										10620 Georgia Ave. N.W.																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
Burial										1-3-1969										Woodlawn Cemetery										Baltimore, Maryland									
24 FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR DATE										25b. REGISTRAR'S SIGNATURE																			
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016										FEB 3 1969										Charles Judge																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) MARY			First L. Middle OGLE Last			2a. DATE OF DEATH Month JAN. Day 6 Year 1969			2b. HOUR 3:10 PM
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 6-9-1903		6 AGE (In years last birthday) 65 YRS.		7 IF UNDER YEAR MONTHS 12 DAYS 14 HOURS 14 MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Adm.			12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4462 MacArthur Blvd.
14 FATHER'S NAME First William E. Middle OGLE Last			15 MOTHER'S MAIDEN NAME First William Middle M. Last Riley			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b SOCIAL SECURITY NO 57760-3516			17 INFORMANT Helen Ogle, Sister, Same						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Massive 412 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive, Cardiovascular, Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. 19 Month 1 Day 5 Year 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1958 , to Jan 6, 1969 , that (I) (we) last saw the deceased alive on Jan 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Frank S. Bacon M.D.				22c DATE SIGNED Jan 6, 1969		22d PHYSICIAN'S NAME (Type) FRANK S. BACON, M.D.			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 1-9-1969		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co., Md.			
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016				25a RECEIVED BY REGISTRAR JAN 13 1969		25b REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Maude Amelia O'Leary</i>						2a. DATE OF DEATH Month <i>Jan.</i> Day <i>2</i> Year <i>1969</i>			2b. HOUR <i>7:10</i> A.M.		
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>Feb. 17, 1881</i>		6. AGE (In years last birthday) <i>87</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Ontario Canada</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Wheaton Nursing Home</i>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5602 Brite Drive</i>			
14. FATHER'S NAME First Middle Last <i>(Unknown) Miller</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth MacWilliam</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) <i>No</i>		16b. SOCIAL SECURITY NO <i>469-14-8541</i>		17. INFORMANT <i>Daughter</i> Address <i>Same as Item 13.</i> <i>Mrs. J.R. Kingston</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Uremia - Chronic Pyelonephritis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>66</i> , to <i>1/2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/1</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. Blaine Fitzgerald</i>		22c. DATE SIGNED <i>1/2/69</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type) <i>J. BIAINE FITZGERALD</i>		22e. ADDRESS <i>8218 Wisconsin Ave. Bethesda, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-4-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Mausoleum</i>		23d. LOCATION (City or Town) (County) (State) <i>San Diego, Calif.</i>					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. RECEIVED BY REG. STAR DATE <i>JAN 6 1969</i>		25b. REG. STAR'S SIGNATURE <i>Charles J. J...</i>							

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 188-221 File 412 MARYLAND STATE DEPARTMENT OF HEALTH
4-30-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

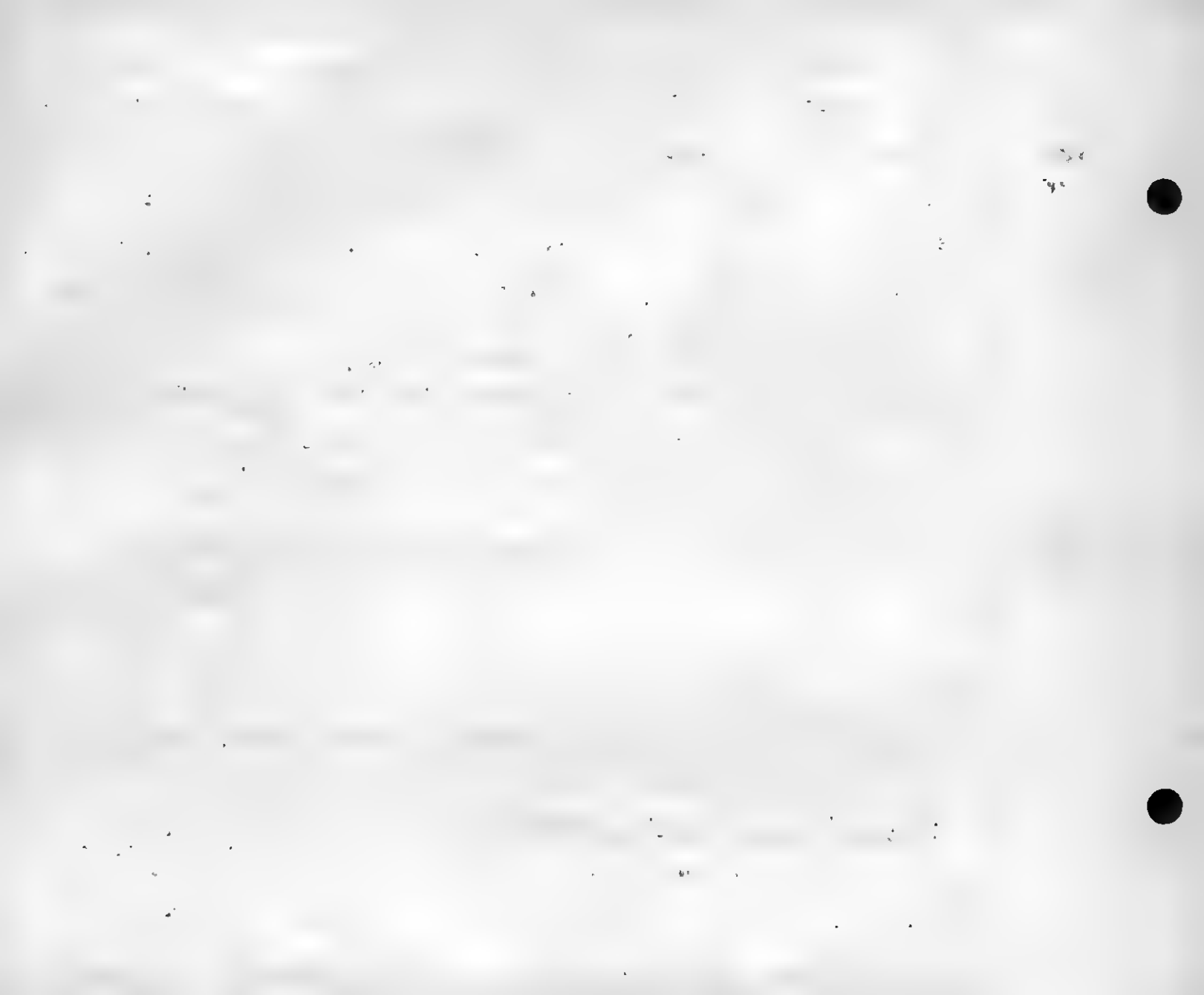
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR			
RUTH MARIE OLSON						MATED <input type="checkbox"/>		1-6-	19	69	1250pm			
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR	
Female	White	6-10-16	52 YRS.					1		6	19	69	1250pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Minn.		USA				Montgomery		Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY								
Takoma Park		Wash. San. & Hosp		Clerk		Navy Dept.								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm'ssion) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Md.		P.G.		Chillum				620 Sheridan St.						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
August Olson						JOHANNA JANSSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
None			UNKNOWN			Hosp. Chart			ARTHUR OLSON STAR RT. DEERWOOD, MINN.					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic coma due														
DUE TO, OR AS A CONSEQUENCE OF														
(b) to Diabetes Mellitus														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			Belden R. Reap, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			JAN. 6, 1969					
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City or Town, and County)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)				
BURIAL		JAN 10, 1969		LAKEWOOD CEM		CROSBY, MINNESOTA								
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE				
W. W. Chambers to Riverdale, Md.								DATE JAN 14 1969		J. W. Jones.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) Emily			First Middle Last NMN Pando			2a. DATE OF DEATH Month Day Year January 26 1969		2b. HOUR 1:05 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 7 May 1909		6 AGE (In years last birthday) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
1d. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Railway Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3311 Brooklawn Terrace	
14. FATHER'S NAME First Middle Last Joseph Garofalo			15. MOTHER'S MAIDEN NAME First Middle Last Antonia de Lorenzo						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 093-09-9841		17 INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Sepsis with Candida pharyngitis, esophagitis 2051 DUE TO, OR AS A CONSEQUENCE OF leukemia (b) Blastic transformation of chronic granulocytic DUE TO, OR AS A CONSEQUENCE OF last. (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 week 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street factory) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that the (this hospital) attended the deceased from 25 Nov. , 19 68 , to 26 Jan. , 19 69 , that it (we) last saw the deceased alive on 26 January , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above it (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard J. Samaha MD				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 27 January 1969			
22d. PHYSICIAN'S NAME (Type) Richard J. Samaha, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 29 JAN. 1969		23c. NAME OF CEMETERY OR CREMATORY Hackensack Cemetery		23d. LOCATION (City or Town) (County) (State) HACKENSACK NEW JERSEY			
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME 7400 GEORGIA AVE. N.W.				ADDRESS DC 20012		25a. REC'D BY REGISTRAR DATE JAN 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



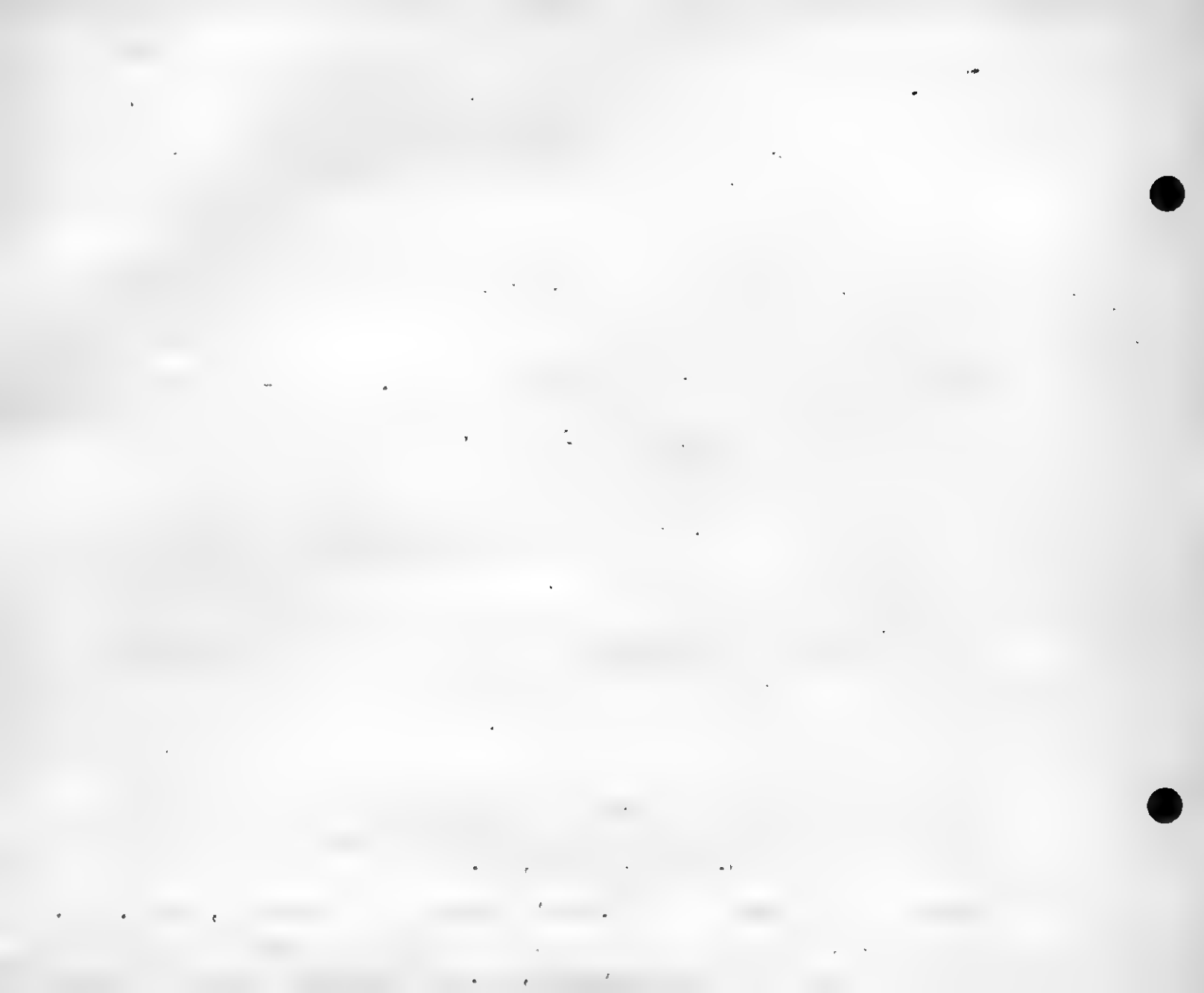
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b HOUR	
Frances M. Parker						Jan 24 1969			7	A	M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
Fe	W.	June 68 1870	98 YRS	MONTHS		DAYS		Jan 24		1969	7	A	M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.				
chic.		U.S.A.				Montgomery							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
Bethesda			Suburban			Housewife							
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER	
Md.			Montgomery			Kensington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2708 Calgary Ave.	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
George Baker			Strickler										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
			215 54 76630J1			James D. Parker - son same item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia.</u>												3 days.	
4404 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Cystitis -</u>												years.	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last													
(c) <u>Generalized Arterio Sclerosis -</u>												years.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
<u>Fracture. Rt. Hip</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
Nov. 22 1968				Repair of Fractured Hip.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
12:30 PM Nov. 19 1968				Fall at home									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
Home				2708 Calgary Ave. Kensington, Mont. Md.									
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED					
John G. Ball				7936 Old Georgetown Road M.D.				Jan 28 1969					
EXAMINER'S NAME (Type)				John G. Ball Bethesda, Md.				ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)	
Burial				1/27/69				St. Mary's Cemetery				Rockville, Montg. Md.	
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home				1331 Rockville Pike				JAN 27 1969				[Signature]	
				Rockville, Md.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A. M. P. M.		
Clara Moore Payton						1-30-69			2:10 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
female		Negro		March 18, 1883			85 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Virginia		America					Montgomery Md			Takoma Park	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Washington Sanitarium				None							
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Washington D.C.				COUNTY				604 60th, N.E.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Jeffery Moore						Hester Moore					Wanzer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
no			579-44-5858			Patient's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary Embolus Bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immobility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Debilitation 2° ASHD + Diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital), attended the deceased from <u>Nov</u> , 19 <u>68</u> , to <u>Jan 30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Bradley Nelson M.D.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1.30.69</u>			
22d. PHYSICIAN'S NAME (Type) <u>BRADLEY NELSON</u>						22e. ADDRESS <u>WASH SAN + HOSP</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2/4/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>				23d. LOCATION (City or Town) (County) (State) <u>Suitland Md</u>			
24. FUNERAL DIRECTOR <u>HOFFMAN'S Funeral Home</u>						25a. REC'D BY REGISTRAR DATE <u>FEB 4 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

VR A15 (4)
30M REV 1/68

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) MARY Elizabeth PETERSON		2a. DATE OF DEATH Month 1 Day 19 Year 1969		2b. HOUR 10^{PM}	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH 9-1-1, 1909	
7a. BIRTHPLACE (State or foreign country) no c.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Montgomery Ward	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY Frederick		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME First Middle Last Williams -- Cummings		15. MOTHER'S MAIDEN NAME First Middle Last Anna -- Bingham		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO 3-1-1-1-1-1-1		17. INFORMANT 9 Mrs. Peterson, Sr. 9507 Georgia St.		Address 1-1-1-1-1-1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive-Arteriosclerotic Vasc. Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 1959 to Jan 19 1969 , that (I) (we) lost the deceased on Jan 19 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bernard A. Fitzgerald		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-19-69	
22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22e. ADDRESS 217 W. BLVD E. SILVER SP. MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-22-1969		23b. DATE 1-22-1969		23c. NAME OF CEMETERY OR CREMATORY Edgewood Memorial	
23d. LOCATION (City or Town) (County) (State) Philadelphia, Pa.		23e. REGISTRATION NO. 1-19-69		23f. REGISTRAR'S SIGNATURE C. Glen Carter	
23g. ADDRESS 1000 S. 10th St. Philadelphia, Pa.		23h. ADDRESS 1000 S. 10th St. Philadelphia, Pa.		23i. ADDRESS 1000 S. 10th St. Philadelphia, Pa.	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or Print) Rocco Pisani										2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> Month Jan Day 10 Year 1969					
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH March 30, 1907		6. AGE (in years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		2b. HOUR 2:35 P.M.			
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			2c. DATE PRONOUNCED DEAD Month 10 Year 69			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 10825 Childs St.				12a. USUAL OCCUPATION (Kind of work done during most of work life, except if retired) Self-employed				12b. KIND OF BUSINESS OR INDUSTRY Self-employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10825 Childs Street			
14. FATHER'S NAME First Joseph Middle Pisani Last Pisani					15. MOTHER'S MAIDEN NAME First Porzia Middle Pisani Last Pisani										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16b. SOCIAL SECURITY NO 528-09-4668					17. INFORMANT Ralph Pisani ADDRESS 9310 Caroline Ave. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Coronary Artery Heart Disease (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease (c) Coronary Artery Heart Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Belden R. Reap Sr.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b. DATE SIGNED JAN. 10, 1969					
EXAMINER'S NAME (Type) Belden R. Reap Sr.					ADDRESS (Street, City, Town, or County) 10825 Childs St. Silver Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE Jan 13, 1969				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Charles E. P. Phrey, Inc. Silver Spring, Md.					25a. RECEIVED BY REGISTRAR DATE JAN 16 1969					25b. REGISTRAR'S SIGNATURE Charles Judge					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

138-1 Film 369
2-11-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01199

1 DECEASED-NAME (Type or Print) <i>Sylvester Pittman</i>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Jan 16 1969			2b HOUR <i>8 P M</i>		
3 SEX <i>male</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>Oct. 9, 1921</i>	6 AGE (In years last birthday) <i>47</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <i>Jan.</i> Day <i>17</i> Year <i>1969</i>		
7a BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Cherry Chase</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>8826 Hawkins Lane</i>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Butcher-grocer</i>		12b KIND OF BUSINESS OR INDUSTRY <i>private</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Cherry Chase</i>		13d INS DE CITY (M 15?) <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>Hawkins Lane</i>
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO. <i>242-14-7045</i>		17 INFORMANT		ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>17-H-4474 Exposure to cold</i> <i>71.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Fatty metamorphosis of liver and cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic alcoholism</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i> <i>Months</i> <i>Years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day, Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John S. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>Jan. 18, 1969</i>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>1-25-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Harmony Cem</i>		23d LOCATION (City or Town) <i>Landover</i>		(County) <i>md</i> (State)
24 FUNERAL DIRECTOR <i>William Spangler</i>				25a REC'D BY REG STRAR <i>JAN 24 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR 11-45M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <u>Roberto</u> <u>TEFFT</u> <u>Polhamus</u>						2a. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1969</u>			2b. HOUR <u>11:15</u> M		
3 SEX <u>Female</u>		4. RACE <u>Cubite</u>		5. DATE OF BIRTH <u>2/12/185</u>		6. AGE (In years last birthday) <u>83</u> YRS		7. UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		8. UNDER 24 HRS HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Tenn</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban Hospital</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEWIFE</u>			
12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY OR TOWN <u>Cherry Chase</u>				13b. INS OF CITY 10M 1ST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET AND NUMBER <u>7410 Ridgewood Road</u>	
14. FATHER'S NAME First <u>William</u> Middle <u>A.</u> Last <u>Tefft</u>			15. MOTHER'S MAIDEN NAME First <u>Emma</u> Middle <u>-</u> Last <u>Young</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <u>217-44-3574</u>		17. INFORMANT <u>LOREN G. POLHAMUS - SAME AS #13</u> Address <u> </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia - Renal Failure</u>										<u>± 6 mo</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephrosclerosis and/or</u>										<u>20 years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pyelonephritis</u>										<u>"</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia, Bronchopneumonia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>69</u> , to <u>Jan 22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death. <u>I did not.</u>											
22b. SIGNATURE <u>James R. Moore Jr. MD</u>						22c. DATE SIGNED <u>Jan 23, 1969</u>					
22d. PHYSICIAN'S NAME (Type) <u>James R. Moore Jr. MD</u>						22e. ADDRESS <u>570 N. Frederick Ave Gaithersburg</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>1/25/69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MD.</u>		
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 5130 WIS. AVE, WASH. D.C.</u>			25a. REC'D BY REGISTRAR <u>JAN 29 1969</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

51

01201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) John Robert Poulton			2a DATE OF DEATH Month January Day 8 Year 1969			2b HOUR 10 45 M	
3 SEX male	4 RACE white	5. DATE OF BIRTH 2/16/18		6 AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS 87	IF UNDER 24 HRS HOURS 45	MIN 10
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County			
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Nurseryman		12b KIND OF BUSINESS OR INDUSTRY Nursery	
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE D.C.		13b CITY OR TOWN WASHINGTON		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1436 Hemlock Street, N.W.	
14 FATHER'S NAME First Thomas E. Middle E. Last Poulton			15. MOTHER'S MAIDEN NAME First Barbara Middle Walters Last Walters				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (na, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 213-38-2028		17 INFORMANT Hospital record Address 7600 Carroll Ave. Washington Sanitarium & Hospital Takoma Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma pancreas DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36-40
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) generalized atherosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/16/68 , 19____, to 1/8 , 19 69 , that (I) (we) lost saw the deceased alive on 1/8/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick Jameson				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/9/69	
22d. PHYSICIAN'S NAME (Type) PATRICK JAMESON				22e. ADDRESS 11718 Georgia Silver Spring, Md.			
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) Burial		23b. DATE 1-11-1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Md. Colmar Manor, Prince Georges Co.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE Jameson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items#5&21, Film DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01202

Item: Film 408 1/23/69 kk

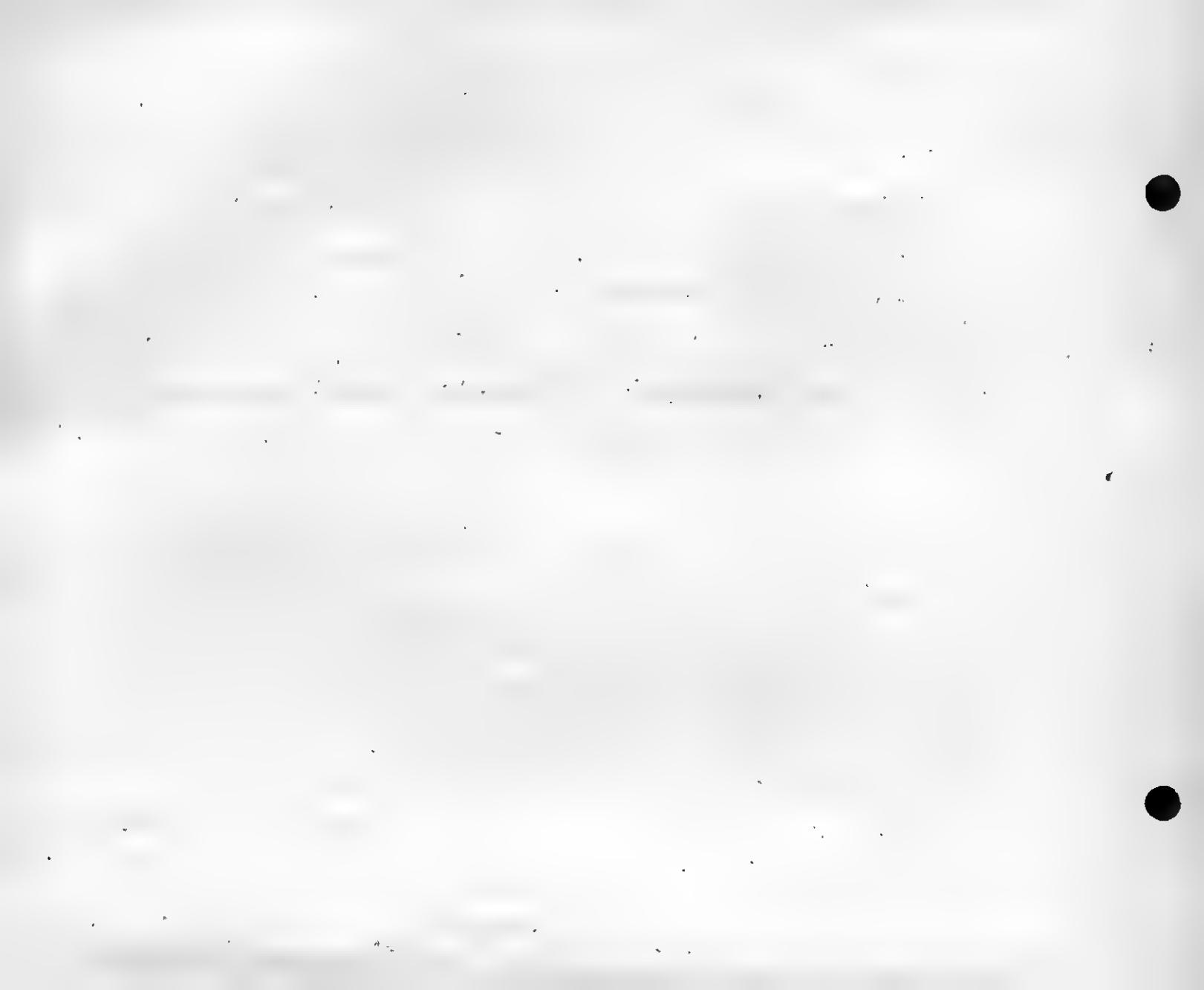
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Alex		01200	J.	Powell	Jan 14 1969			
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		April 17 1926		42 YRS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Pennsylvania		USA				Montgomery Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross		Broker		Real Estate		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Montgomery		Wheaton				2002 Plyers Mill Rd.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Alexander		J.		Pavlovic	Joanna		H.	Stanavich
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
Yes		172-20-7571		Mary Louise Powell		Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) POLYCYSTIC KIDNEYS RENAL FAILURE								CONGENITAL
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
NONE								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1964, to 14 JAN, 1969, that (I) (we) last saw the deceased alive on 14 JAN 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
WALTER E. GOOZT MD								15 JAN 69
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
WALTER E. GOOZT MD				2309 SHOREFIELD RD WHEATON MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Jan 17, 1969		Parklawn Cemetery		Rockville Mont. Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Hallis 500 University Blvd N Silver Spring Md				JAN 20 1969		Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01201										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01203																													
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
Katharine C. Price										JAN 18 1969										10 PM																													
3 SEX										4 RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)																			
Female										CAU										7-30-10										38 YRS.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																			
WASH. D.C.										U.S.A.																				Montgomery Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																			
Silver Spring										HOLY CROSS										HOUSEWIFE																													
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NP <input type="checkbox"/>										13e. STREET AND NUMBER									
Maryland										Montgomery										Cherry Chase										8200 Colston Place																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																							
CECIL LEROY BLAKE										FRANCIS EVORA EDGE COMB																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO										17 INFORMANT										Address																			
NO										217-36-9008										DAVID G. PRICE										8200 COLSTON PL. CHERRY CHASE, MD																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
										Gram negative Septicemia										hrs.																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b)										days																													
										Fecal Fistula																																							
										DUE TO, OR AS A CONSEQUENCE OF (c)										few months																													
										Carcinoma of Colon																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
Acute myocardial infarction																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
12/23/68										Intestinal obstr.										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
										HOUR A.M. Month Day Year																																							
										P.M. 19																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)										21f. LOCATION										City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										22c. DATE SIGNED																																							
G. LEONARD GOLD										11/18/69																																							
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																							
G. LEONARD GOLD										9801 Georgia Ave. Silver Spring, Maryland																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
BURIAL										1-22-69										CEDAR HILL										SUTHERLAND MD																			
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
ROBERT A. PUMPHREY										7517 LUISA AVE BETH - MD										JAN 23 1969										[Signature]																			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First JAMES			Middle C.			Last RAGLAND			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 1 DAY 24 YEAR 1969	2b. HOUR 12AM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 1/20/03	6 AGE (In years last birthday) 66 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0	2c. DATE PRONOUNCED DEAD MONTH 1 DAY 24 YEAR 1969			2d. HOUR 12AM			
7a. BIRTHPLACE (State or foreign country) WASH. DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY COUNTY Md				
10. CITY OR TOWN OF DEATH Silver Spring, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) INVESTIGATOR			12b. KIND OF BUSINESS OR INDUSTRY US GOVT				
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE MD			13b. COUNTY PG			13c. CITY OR TOWN LAUREL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6705 McCAHILL DR.	
14. FATHER'S NAME First JOHN Middle R Last RAGLAND			15. MOTHER'S MAIDEN NAME First ROSE Middle CONNOR Last CONNOR										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO. 578-10-1537			17. INFORMANT JOHN ENDERS - ABOVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conflagration Burns 60% DUE TO, OR AS A CONSEQUENCE OF Body Surface, Bedding ignited Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost while smoking in bed. (b) while smoking in bed. (c) while smoking in bed.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year 1/23/69				21c. HOW INJURY OCCURRED (Give nature of injury in Part 1 or Part 2 Item 18) Deceased, given no, was smoking in bed					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Living Home				21f. LOCATION Street or R.F.D. No City or Town County, State Fairland, Reg. Home, S.S. Montg. Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Jan. 24, 1969					
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County) Laurel Md					
23a. BURIAL, CREMATION, OR OTHER (Specify) BURIAL				23b. DATE 1/27/69				23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM				23d. LOCATION (City or Town) (County) (State) SUITLAND MD	
24. FUNERAL DIRECTOR Donald H. Laurel Md				ADDRESS				25a. REC'D BY REGISTRAR JAN 29 1969				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, provide funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1 DECEASED-NAME (Type or print) Mary			First W			Middle Rash			2a. DATE OF DEATH Month 1 Day 20 Year 69			2b. HOUR 3:30 p.			
3. SEX Female			4. RACE White			5. DATE OF BIRTH Sept. 27, 1887			6. AGE (In years last birthday) 81 YRS			IF UNDER YEAR MONTHS 8	IF UNDER YEAR DAYS 20	IF UNDER YEAR HOURS 3:30	IF UNDER YEAR MIN 30
7a. BIRTHPLACE (State or foreign country) Ohio			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			MD			
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jefferson Valley			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 625 Azalea Dr., Rockville			
14. FATHER'S NAME Hiram			First Webber			Middle Emma			15. MOTHER'S MAIDEN NAME Woods			First Woods			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO None			17. INFORMANT Mrs. Betty Murphy, 625 Azalea Dr.			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia												6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												years			
(b) Generalized arteriosclerosis															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic heart disease															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Jan 20, 1969 , to Jan 20, 1969 , that (I) (we) last saw the deceased alive on Jan 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE G. Bowditch Hunter, Jr.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Jan. 20, 1969						
22d. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.						22e. ADDRESS 50 W. Edmonston Dr., Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Jan. 23, 69			23c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery			23d. LOCATION (City or Town) (County) (State) Greenville, Ohio						
24. FUNERAL DIRECTOR ROBERT A. PUMIHREY, ROCKVILLE, MARYLAND						ADDRESS 24 1969			25a. REGD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				

**FOR STATE
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

012

01266

1 DECEASED NAME (Type or Print) Meyer			First Middle Last None Ratner			2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1-30 1969			2b HOUR 6A		
3 SEX Male		4 RACE White		5 DATE OF BIRTH 1-14-14		6 AGE (In years last birthday) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) D. C.			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b KIND OF BUSINESS OR INDUSTRY Liquor	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.				13b COUNTRY Montgomery		13c CITY OR TOWN Sil. Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1220 East West Hwy.	
14 FATHER'S NAME First Middle Last Mose Ratner			15. MOTHER'S MAIDEN NAME First Middle Last Jennie Millman			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO 577-05-7840		
17 INFORMANT Anne Ratner,			ADDRESS Same as 13								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) White Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Beard M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS. STANT MED. CA. EXAMINER <input type="checkbox"/>			22b DATE SIGNED JAN. 30, 1969		
EXAMINER'S NAME (Type) BELDEN R. BEARD M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-31-69		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery			23d. LOCATION (City or Town) Hyattsville		(County) Md.		(State)
24 FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th St., N.W.						ADDRESS		25a REC'D BY REGISTRAR FEB 4 1969		25b REGISTRAR'S SIGNATURE R. Charles Under	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) MORRIS			First MORRIS Middle Refson Last Refson			2a. DATE OF DEATH Month 1 Day 22 Year 69		2b. HOUR 10 A. M.	
3 SEX male		4 RACE White		5 DATE OF BIRTH 4-4-88		6 AGE (in years last birthday) 80 YRS		7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a BIRTHPLACE (State or foreign country) Lithuania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md			
10. CITY OR TOWN OF DEATH Kensington		11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) Nursing Home Kensington Garden		12a USUAL OCCUPATION (kind of work done during most of working life, even if retired.) Junk Yard Business		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, Res. date before admission) STATE MD COUNTY Montgomery		13c CITY OR TOWN Laurel		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3941 Greencastle Road			
14. FATHER'S NAME First Jacob			15. MOTHER'S MAIDEN NAME First Refson			Middle Refson Last Refson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 374-24-9802		17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pneumonia DUE TO, OR AS A CONSEQUENCE OF Chronic Heart Failure Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost Chronic Heart Failure DUE TO, OR AS A CONSEQUENCE OF Arterio-sclerotic H.P. (c) Arterio-sclerotic H.P.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 1 Day 22 Year 69 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No Jan 18, 19 69 City or Town Jan 22, 19 69 County Jan 22, 19 69 State Jan 22, 19 69					
22a. I certify that (I) (this hospital) attended the deceased from Jan 18, 19 69 to Jan 22, 19 69 , that (I) (we) last saw the deceased alive on Jan 20, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert T. Talbadeau		22c. DATE SIGNED 1-22-69		22d. PHYSICIAN'S NAME (Type) ROBERT T. TALBADEAU					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia		23e. REC'D BY REGISTRAR JAN 27 1969	
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll St., N.W. Wash., D.C.		25a. REGISTRAR'S SIGNATURE Hebrew Memorial Funeral Home		25b. REGISTRAR'S SIGNATURE Hebrew Memorial Funeral Home			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01208		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print) <i>HEATHER Ann Reid</i>						2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Jan 20 1969			2b HOUR 11:25 M			
3 SEX <i>Female</i>		4 RACE <i>W.</i>		5 DATE OF BIRTH <i>1/1/50</i>		6 AGE (in years last birthday) <i>19</i> YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Minnesota</i>		7b CIT ZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			2d HOUR 11:25 M			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>				12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Student</i>			12b KIND OF BUSINESS OR INDUSTRY	
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Montgomery</i>				13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Earthstone</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>13201 Darnestown Road</i>		
14 FATHER'S NAME First <i>Jack</i> Middle <i>D</i> Last <i>Reid</i>				15 MOTHER'S MAIDEN NAME First <i>MARGARETTE</i> Middle <i>Sydney</i> Last <i>Reid</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b SOCIAL SECURITY NO <i>215-50-9605</i>		17 INFORMANT <i>Jack Reid - father - add name</i>			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intra cerebral hemorrhage</i>										10 days		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Basilar Skull Fracture</i>										10 days		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Auto Accident</i>										10 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <i>10:25 PM Jun 10 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Auto Accident</i>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Street</i>		21f. LOCATION Street or RFD No. City or Town County State <i>700 Block N. Horner's Lane, Rockville, Mont. Md.</i>								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>Jan 24 1969</i>				
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REBURYAL (Type) <i>Burial</i>		23b. DATE <i>1/23/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Mem. Park</i>				23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg. Maryland</i>				
24. FUNERAL DIRECTOR <i>Tyson Wheeler F.H. L331 Rockville Pike Rockville, Maryland</i>						25a. REC'D BY REGISTRAR <i>JAN 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

31209

1 DECEASED-NAME (Type or print) <i>William A. Riely</i>			2a DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>1969</i>			2b HOUR <i>5:30 A</i> M					
3. SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>10-19-1897</i>		6 AGE (in years last birthday) <i>71</i> YRS		7 UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		8 UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a BIRTHPLACE (State or foreign country) <i>West Va.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.					
10 CITY OR TOWN OF DEATH <i>Rockville</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Anne's Home</i>			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Religious Personnel</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution and residence before admission) STATE <i>md.</i>			13b COUNTY <i>Montg</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>Rt. #1</i>		
14 FATHER'S NAME First <i>Philip</i> Middle <i>H.</i> Last <i>Riely</i>			5 MOTHER'S MAIDEN NAME First <i>Amanda</i> Middle <i>Kearns</i> Last <i></i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <i>217-36-6741</i>		17 INFORMANT <i>Mrs. Alice Riely</i>			Address <i>Rockville Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure</i> <i>185X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <i>Metastatic carcinoma to brain</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Adenocarcinoma of prostate</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>1 month</i> <i>18 months</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>											
19a DATE OF OPERATION <i>none</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1967, to <i>Jan 4</i> , 1969, that (I) (we) last saw the deceased alive on <i>Jan 4</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>John P. Maylath, MD</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>Jan 4, 1969</i>					
22d PHYSICIAN'S NAME (Type) <i>JOHN P. MAYLATH</i>				22e ADDRESS <i>50 W EDMOND ST ROCKVILLE, MD</i>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>1/7/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove</i>		23d LOCATION (City or Town) (County) (State) <i>Heardon Fairfax Va.</i>					
24 FUNERAL DIRECTOR <i>W.C. Hutton</i>		ADDRESS <i>Barnesville, Md.</i>		25a REC'D BY REGISTRAR <i>Jan 8 1969</i>		25b REGISTRAR'S SIGNATURE <i>W.C. Hutton</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 2 and 3) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01210

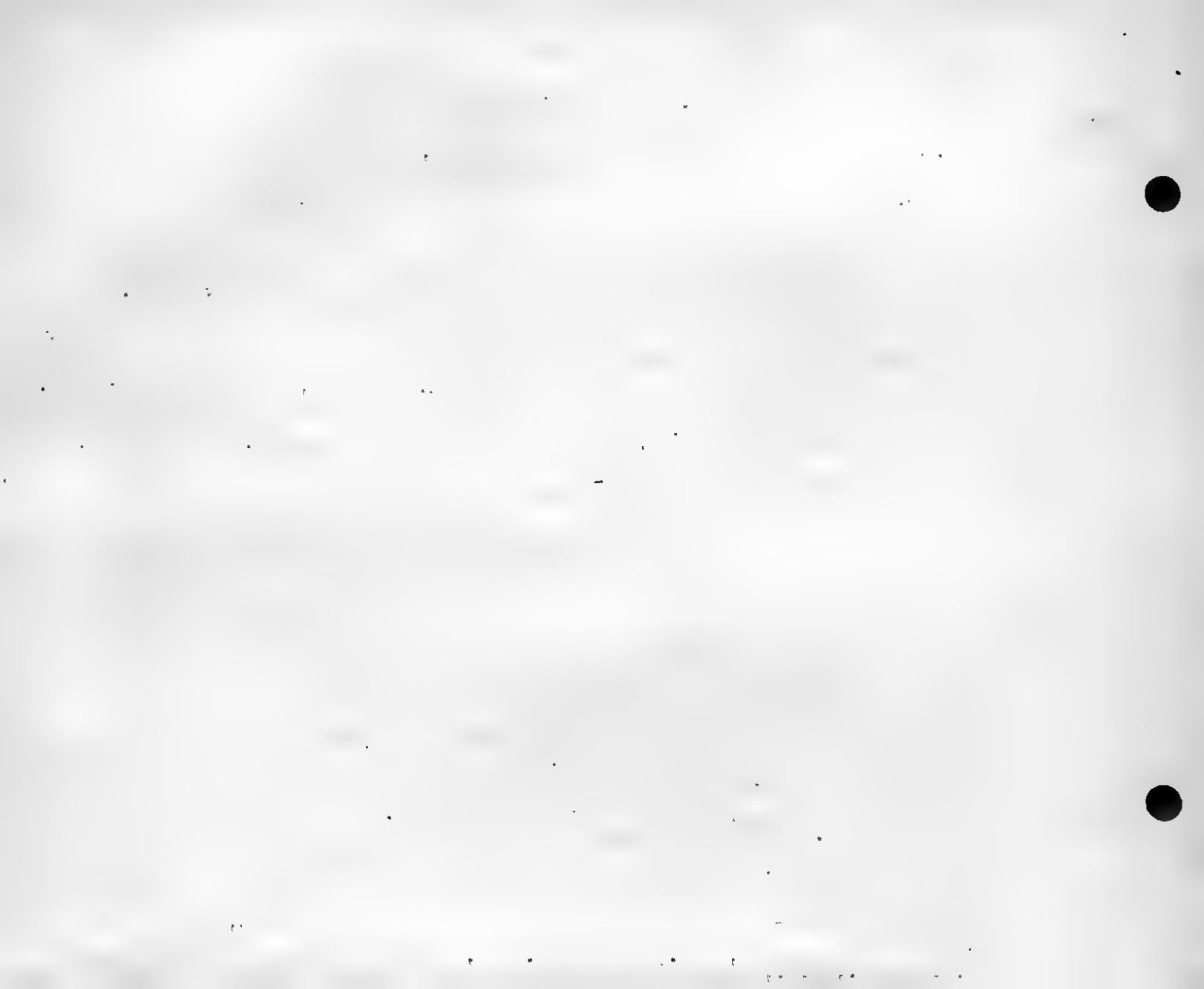
1 DECEASED-NAME (Type or print) Eugenia A Riley			2a DATE OF DEATH Month Jan Day 11 Year 1969			2b HOUR 9:30 AM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH Oct 13 1891		6 AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4528 Chestnut St			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY At Home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE Md.			13b COUNTY Montgomery			13c CITY OR TOWN Bethesda			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e STREET AND NUMBER 4528 Chestnut St.			14 FATHER'S NAME First Middle Last Philip Houser			15 MOTHER'S M.A.DEN NAME First Middle Last Harriet Burroughs				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No (If yes give year or dates of service)			16b SOCIAL SECURITY NO. 213-56-1812			17 INFORMANT Dorothy E Federline			Address 9905 Parkwood Drive Bethesda, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction									5-8 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure									5 Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Severe Generalized Atherosclerosis										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from June 19 49 to Jan 11 1969 , that (I) (we) last saw the deceased alive on 1-11 1969 , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE P. P. Andrews MD						22c DATE SIGNED 1-11-69				
22d PHYSICIAN'S NAME (Type) P. P. ANDREWS						22e ADDRESS 4201 Wisconsin Ave Washington, DC				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 1-14-69			23c NAME OF CEMETERY OR CREMATORY Potomac Methodist			23d LOCATION (City or Town) (County) (State) Potomac Mont. Maryland	
24 FUNERAL DIRECTOR Robert A Pumphrey						7557 Wisconsin Ave Bethesda, Md			25 REC'D BY REGISTRAR JAN 15 1969	
						25a REGISTRAR'S SIGNATURE [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with Medical Examiner - R. J. [illegible]

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) EDITH C. ROBINSON						2a. DATE OF DEATH Month 1 Day 21 Year 69			2b. HOUR 7:40 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 8, 1884			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Maine		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md			
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At home			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14409 Oakvale St.		
14. FATHER'S NAME First Lyman Middle Fales Last Fales				15. MOTHER'S MAIDEN NAME First Martha Middle Facett Last Facett								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. -		17. INFORMANT Address Carlton A. Robinson, Son, same as #13 item.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Old age (c) Old age										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 11 Month 1 Day 21 Year 69 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 3 FAVAR		City or Town Rockville		County Montgomery		State Md		
22a. I certify that (I) (this hospital) attended the deceased from 1/21, 1969 to 1/21, 1969 that (I) (we) lost saw the deceased alive on 1/21, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Richard A. Delelany						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/22/69				
22d. PHYSICIAN'S NAME (Type) Richard A. Delelany						22e. ADDRESS 3 FAVAR						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-25-1969		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) Farmington, Maine				
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave., N.W., Wash., D.C., 20016						25a. REC'D BY REGISTRAR JAN 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Mabel		Middle Jane		Last Robinson		2a. DATE OF DEATH 1 Month 1 Day 69 Year		
3 SEX Female		4. RACE Negro			5. DATE OF BIRTH 9/8/1901			6. AGE (In years last birthday) 67 YRS		2b HOUR M	
7a. BIRTHPLACE (State or foreign country) Culpepper, Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Wheaton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1110 Nora Drive	
14. FATHER'S NAME First Goldring				Middle Gray		15. MOTHER'S MAIDEN NAME First Annie				Middle Doors	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no				16b. SOCIAL SECURITY NO (If yes give war or dates of service) 224-32-2193		17 INFORMANT Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angina</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>442 X</u> (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>I. Only significant heart disease II. Diabetes Mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY) OFFICE BUILDING ETC				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> , 19 <u>67</u> , to <u>12/31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Lawrence C. Cannaday, M.D.</u>						DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/1/69	
22d. PHYSICIAN'S NAME (Type) LAWRENCE C. CANNADAY, M.D.						22e. ADDRESS 3632-GEORGIA AVE. N.W.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/5/69		23c. NAME OF CEMETERY OR CREMATORY Upper 7100				23d. LOCATION (City or Town) Silver Spring		(County) (State)	
24. FUNERAL DIRECTOR V.W. Chambers, Inc.						25a. REC'D BY REG STRA DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them in the proper folder. This certificate should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 141
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Mary none Rogers			2a. DATE OF DEATH Month Day Year 1 25 69		2b. HOUR 6:20A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Nov 23, 1914		6. AGE (In years last birthday) 54 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) D C	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Pk	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash San & Hospital		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) waitress		12b. KIND OF BUSINESS OR INDUSTRY Statler-Hilton
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Montgomery	13c. CITY OR TOWN Mt Airy	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Route #3	
14. FATHER'S NAME First Middle Last Frank Selvaggio		15. MOTHER'S MAIDEN NAME First Middle Last Teresa unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO 578-16-3679	17. INFORMANT Address Diane Bernet 11308 Vires Mill Rd Wheaton			
18. CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>431.0 CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUBACUTE BACTERIAL ENDOCARDITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF (d) <u></u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cholerae Mellitus Mild.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>69</u> to <u>1-25</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1-24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John L Ford MD</u>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) JOHN LOUIS FORD			22e. ADDRESS 831 UNIVERSITY BLVD SILVER SPRING, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/28/69	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR DATE JAN 30 1969		25b. REGISTRAR'S SIGNATURE <u>John L Ford</u>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED-NAME (Type or Print)			First <i>Pearl</i>			Middle <i>Elizabeth</i>			Last <i>Rose</i>			2a DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> <i>Jan 16 1969</i>	2b HOUR <i>12 noon</i>		
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>June 30, 1888</i>	6 AGE (In years last birthday) <i>80</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		2c DATE PRONOUNCED DEAD Month <i>January</i> Day <i>16</i> Year <i>1969</i>			2d HOUR <i>12 noon</i>				
7a BIRTHPLACE (State or foreign country) <i>Penna</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Montgomery</i>						
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San & Hospital</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>			12b KIND OF BUSINESS OR INDUSTRY <i>house</i>						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b CITY OR TOWN <i>Montgomery</i>			13c CITY OR TOWN <i>Silver Spring</i>			13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <i>8519-11th Avenue</i>			
14 FATHER'S NAME First <i>Thomas</i> Middle <i>W</i> Last <i>Richards</i>			15 MOTHER'S MAIDEN NAME First <i>Willie</i> Middle <i>Maude</i> Last <i>Richards</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO <i>114</i>			17 INFORMANT <i>Ernest D. Rose 8519 11th Avenue, Silver Spring, Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia, Acute, Bilateral</i> <i>486X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. <i>8519</i>				City or Town <i>Silver Spring</i>		County <i>Montgomery</i>		State <i>Md.</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>JAN. 17, 1969</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>1-20-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>				23d LOCATION (City or Town) <i>Washington, D.C.</i>		County <i>D.C.</i>		State <i>D.C.</i>			
24 FUNERAL DIRECTOR <i>P.J. Smith</i>				ADDRESS <i>Warner E. Humphrey, 8134 Georgia Ave. N.E.</i>				25a READ BY REGISTRAR <i>JAN 23 1969</i>		DATE		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office for filing. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			2b HOUR
Leonard Louis Rosenberg						Month	Day	Year	4 a M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD			2d HOUR
M	W	11-30-1922	46			Month	Day	Year	4 a M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 RIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH			10
New York		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery			MD
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Takoma Park, Md.			Washington San & Hops.						
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Mr.			Mont.			Sil. Spring			8445 12th Ave.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
HENRY					ROSENBERG	EDNA			MANDELBAUM
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS
Yes			WW 2			072-14-3062			Howard Tossman, 11644 Lockwood Dr. Sil. Spring
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chute Coronary Insufficiency</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. P.M. 19						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
Belden R. Reap			M.D.			JAN. 31, 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, City, Town, County)			
BELDEN R. REAP			M.D.						
23a BURIAL, CREMATION OR REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			2/2/69		Mount Lebanon Cemetery		Hyattsville, Prince Geo. Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Donald M. Stein			232 Carroll			FEB 4 1969		John J. Jones	
Hebrew Memorial Funeral Home, Washington, D. C.									

01220

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR	
Elizabeth Anne Gill				RUFFIN	January		14	69	2:45 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
Female	Caucasian		30 July 1921		47 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Illinois		USA				Montgomery		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Naval Hospital		Housewife		N/A				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Virginia		Arlington		Arlington				Apt. B1210, 1600 S. Joyce St		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		
Philip T. SPRAGUE		Marguerite Allock				551 70 0699		1600 S. Joyce Street, Arlington Capt. Chester E. Ruffin, USN, Apt. B1210		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the breast with widespread metastases										
174X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Jan 11, 1969, to Jan 14, 1969, that (X) (we) lost saw the deceased alive on Jan 14, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Marvin N. Goldstein MD				22c. DATE SIGNED Jan. 15, 1969				22d. PHYSICIAN'S NAME (Type) Marvin N. Goldstein, M. D.		
22e. ADDRESS Naval Hospital, Bethesda, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		11/16/68		Cedar Hill Crematory		Suitland Md.				
24. FUNERAL DIRECTOR Murphy Funeral Home 3524 Columbia Pike, Arlington, Virginia				25a. REC'D BY REGISTRAR C.M. France JAN 17 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

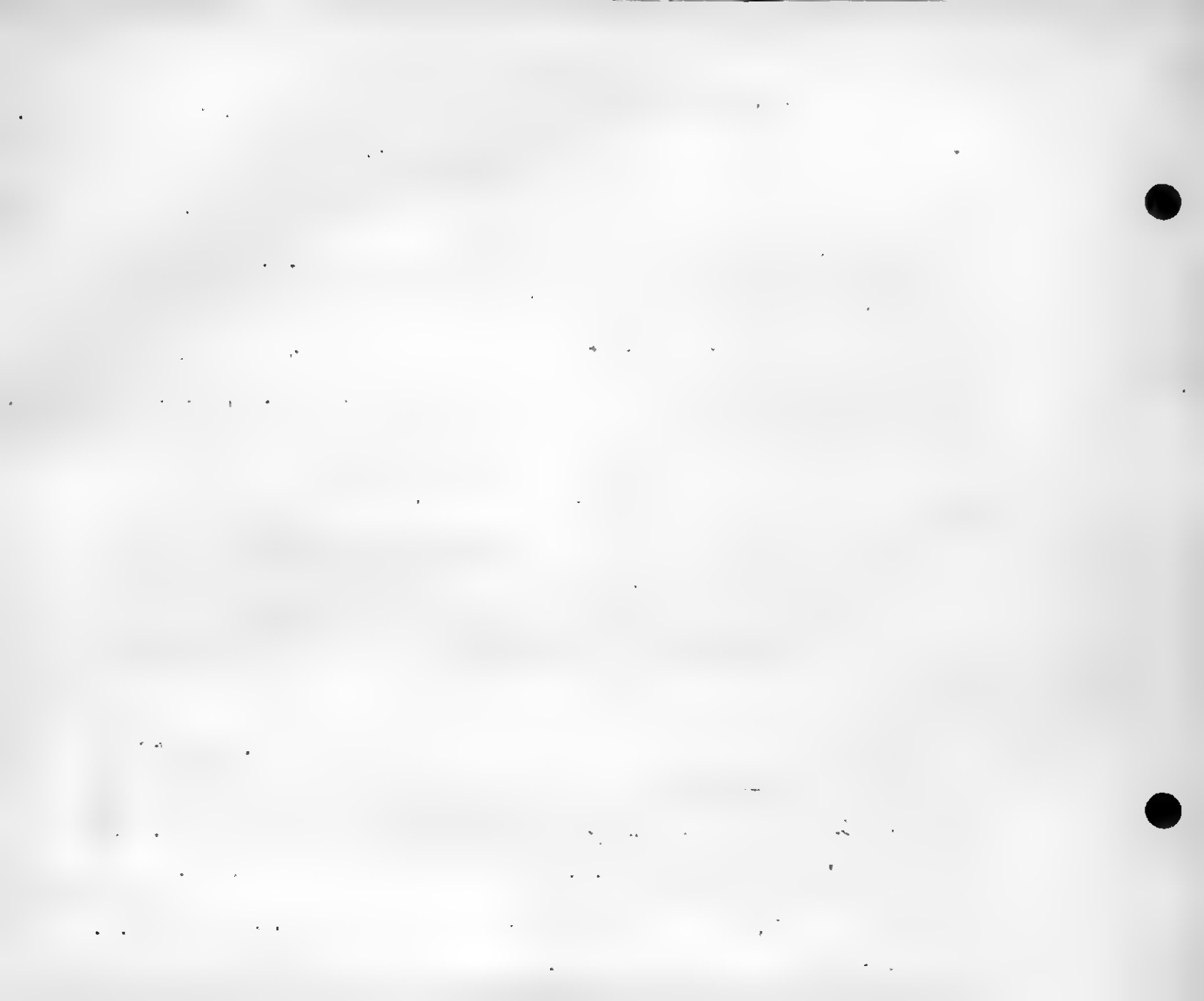
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01221 CERTIFICATE OF DEATH 01217											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Gertrude			Scott Runyan			Jan. 1, 1969			2 A.M.		
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Feb. 15, 1874		94 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Iowa		USA				Montgomery Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg			R.D. # 2			Housewife					
13a. JSJAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM. IS?		13e. STREET AND NUMBER		
Maryland			Montgomery		Gaithersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. # 2		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Joseph Addison Scott			Elizabeth Crawford								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No						Mrs Dorothy R. Harding, Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis											3 months
4123 DUE TO, OR AS A CONSEQUENCE OF											
Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Arteriosclerosis, Gen'l											years
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Gouty Arthritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1969, to Jan. 1, 1969, that (I) (we) last saw the deceased alive on Dec. 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Jack Schumacher										Jan. 1, 1969	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Jack Schumacher, M.D.						Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 3, 1969		Glenwood		Washington, D.C.					
24. FUNERAL DIRECTOR ADDRESS						25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, Damascus, Md.						JAN 6 1969		Charles Judge			

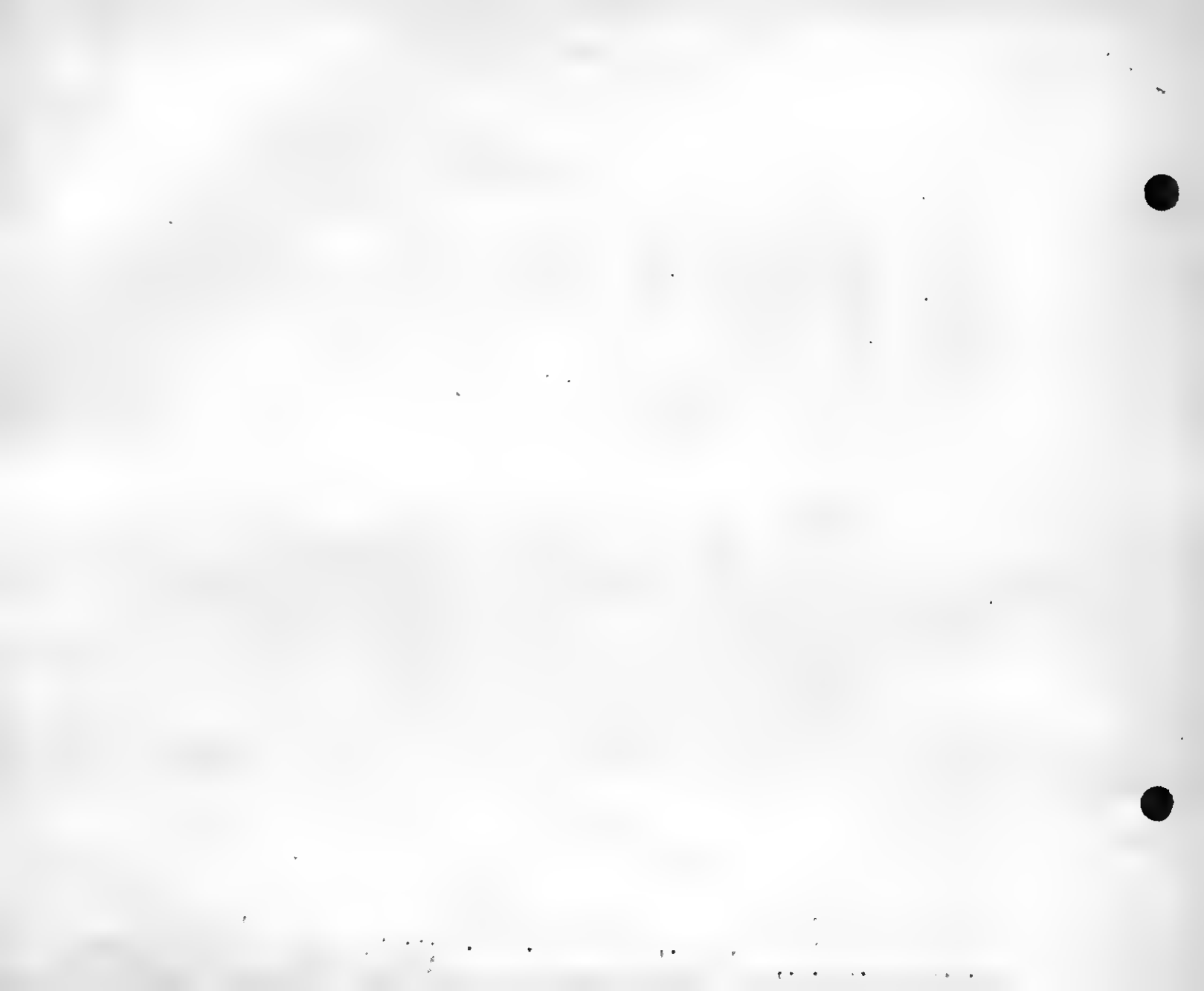
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			Month	Day	Year	2b. HOUR
Lillian C. Russe									1	10	69	2:30 A.M.
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Caucasian		10-14-81		87 YRS		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Alabama		U.S.A.				Montgomery						
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY						
Chevy Chase		Bethesda Silver Spring Nursing Home		At Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. CITY OR TOWN		13c. WIDE CITY LIMITS?		13e. STREET AND NUMBER						
Maryland		BETHESDA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6210 Varlick Lane						
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		
MILLARD		SAMUELSON		CARTER				TRISCOLLA		CLARKE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOC. A. SECURITY NO.		17 INFORMANT		Address				
				416-03-5883		MR. STANLEY B. RUSSELL, SEN, SAME AS #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma												
1541 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) Adenocarcinoma of Rectum												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
6 mos												
18 mos												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
1) Hypertensive Cardiovascular Disease, 2) Diabetes, 3) Gout												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from Aug, 1960, to Jan, 1969, that (I) (we) last saw the deceased alive on 1-6-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED						
Francis J. Murray MD						1-10-69						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
FRANCIS J. MURRAY		1601-15th St. N.W., Wash., D.C.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Removal		1-11-1969		Evergreen Cemetery		Sylacauga, Alabama						
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016		JAN 15 1969		J. Gawler, Jr.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1 DECEASED-NAME (Type or print) <u>Thomas A Ryan</u>						2a. DATE OF DEATH <u>January 10 1969</u>			2b. HOUR <u>2:50 PM</u>		
3 SEX <u>Male</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH <u>10/2/1895</u>		6 AGE (In years last birthday) <u>73</u> -YRS.		F UNDER MONTHS		IF UNDER 24 HRS HRS MIN	
7a. BIRTHPLACE (State or foreign country) <u>U.S.A. N.Y.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery - Md</u>					
10. CITY OR TOWN OF DEATH <u>Wheaton -</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Handwich Hills Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Steel Die Finisher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Metal</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>BETHESDA</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>9712 PARKWOOD DRIVE</u>			
14. FATHER'S NAME First <u>THOMAS</u> Middle <u>RYAN</u> Last <u>UNK</u>				15. MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>UNK</u> Last <u>UNK</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>089-03-8847-A</u>		17 INFORMANT <u>MRS. SAMUEL LANK, DAUGHTER</u> Address <u>See # 13</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA - PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 YR</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 6 MYS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 10</u> , 19 <u>69</u> , to <u>JAN 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>JAN 10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>DR LEO I DONOVAN</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/10/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>DR LEO I DONOVAN</u>		22e. ADDRESS <u>8218 WISCONSIN AVE BETHESDA</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan 14, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodside Long, Island, NY</u>					
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u> ADDRESS <u>5130 Wisconsin Av., NW Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>JAN 15 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) Frank Salasin						2a DATE OF DEATH Month January Day 31 Year 1969			2b HOUR 2 P M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH 1/1/89		6 AGE (In years lost birthday) 80 YRS			7 IF UNDER 1 YEAR MONTHS DAYS 		8 IF UNDER 24 HRS. HOURS MIN 	
7a BIRTHPLACE (State or foreign country) Russia		7b CITIZEN OF WHAT COUNTRY? U.S. A.		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10 CITY OR TOWN OF DEATH Wheaton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home - Boulder		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Builder			12b KIND OF BUSINESS OR INDUSTRY CONSTR.					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8019 Whittier Blvd.				
14. FATHER'S NAME First Israel Middle Last Salasin				15. MOTHER'S MAIDEN NAME First Rachel Middle L. Sincoff Last 								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 186-05-0781		17. INFORMANT Address Alfred M. Salasin - 8019 Whittier Blvd. Bethesda, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) Acute osteomyelitis, left hip												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
CEREBRAL ARTERIOSCLEROSIS												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or RFD No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from 1967 , 19 1-31 , 19 1969 , that (I) (we) last saw the deceased alive on 1-28 19 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Stanley W. Kirstein M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 1-31-69				
22d PHYSICIAN'S NAME (Type) Stanley W. Kirstein M.D.						22e ADDRESS 5410 Conn. Ave. N.W., D.C.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE FEB. 2, 1969		23c NAME OF CEMETERY OR CREMATORY King David Memorial Garden		23d LOCATION (City or Town) (County) (State) Falls Church, Va.						
24 FUNERAL DIRECTOR Bernard Danzansky & Sons						25a REC'D BY REGISTRAR FEB 6 1969		25b REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

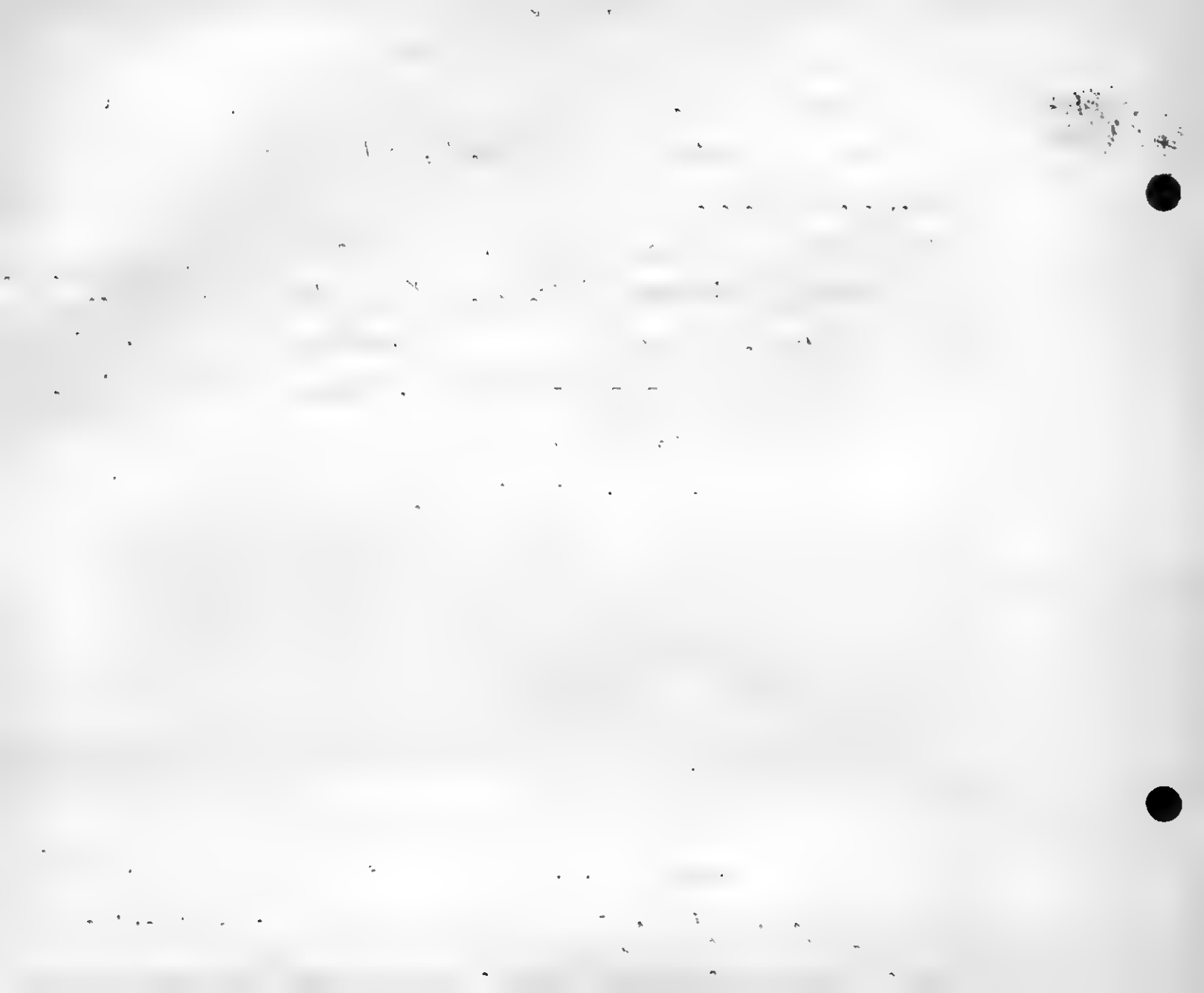
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) <i>Paul</i> First <i>Anthony</i> Middle <i>Santoro</i> Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED <i>Jan 29 1969</i> Month Day Year		2b HOUR <i>1:50</i> M
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>9/23/06</i>	6 AGE (in years and birthday) <i>62</i> YRS	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) <i>Italy</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>	12b KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Mont</i>	13c CITY OR TOWN <i>Bethesda</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>9505 Milstead Rd</i>
14. FATHER'S NAME First <i>Ralph</i> Middle <i>Santoro</i> Last	15 MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>	
16b SOCIAL SECURITY NO <i>unknown</i>		17 INFORMANT <i>Edith Santoro</i> ADDRESS <i>Same as above</i>		17b ADDRESS <i>9505 Milstead Dr. Md</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4123</i> <i>coronary Insufficiency Acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <i>Jan 29 1969</i>
EXAMINER'S NAME (Type) <i>John G Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<i>Bethesda, Md</i>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>1-30-69</i>	23c NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	23d LOCATION (City or Town) <i>Silver Spring</i> (County) <i>Mont.</i> (State) <i>Md</i>	
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a REGISTRATION DATE <i>FEB 3 1969</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Gertrude C. Sartain</i>						2a. DATE OF DEATH Month Day Year <i>Jan. 29 1969</i>			2b. HOUR <i>9:00</i>		
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Dec. 10, 1891</i>		6. AGE (In years last birthday) <i>77 7/8</i> YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1104 Woodside Pkwy.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1104 Woodside Pkwy.,</i>			
14. FATHER'S NAME First Middle Last <i>Charles J. Tracy</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Delia Ledwith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes, or unknown</i>				16b. SOCIAL SECURITY NO <i>577-05-5939-8</i>		17. INFORMANT Address <i>William C. Sartain 1104 Woodside Pkwy.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolus</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of breast with metastasis to the brain</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 months</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>5/11</i> , 19 <i>66</i> , to <i>1/29</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>1/29</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Thomas F. Collins M.D.</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/29/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Thomas F. Collins, M.D.</i>						22e. ADDRESS <i>2600 Queens Chapel Road, Hyatts Md.</i>					
23a. BURIAL, CREMATION, or other disposition <i>Buried</i>		23b. DATE <i>Feb. 1, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Forest Glen, Mont., Md.</i>					
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>						ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A1
45M

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print) <i>Harrison</i>			First <i>Harrison</i>			Middle <i>* Sasser</i>			Last <i>Sasser</i>			2a DATE OF DEATH Month <i>Jun</i> Day <i>19</i> Year <i>69</i>			2b HOUR <i>4:30</i> M		
3 SEX <i>M</i>			4 RACE <i>White</i>			5. DATE OF BIRTH <i>11/15/23</i>			6 AGE (In years and birthday) <i>45</i> YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Montgomery</i>								
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Dr. U. COLLEGE</i>			12b KIND OF BUSINESS OR INDUSTRY			EDUCATION					
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>Maryland</i>			13b COUNTY <i>Mont.</i>			13c CITY OR TOWN <i>Ching Chuan</i>			3d INS DE CITY L.M. 15? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <i>4856 Ching Chuan Blvd</i>					
14 FATHER'S NAME First <i>Henry H.</i> Middle <i>Sasser</i> Last <i>Sasser</i>			MOTHER'S MAIDEN NAME First <i>Cora</i> Middle <i>Hudson</i> Last <i>Hudson</i>			15 INFORMANT (AUNT) <i>Lige Moffett, Ching Chuan</i>			Address <i>4856 Ching Chuan Blvd.</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>			6b SOCIAL SECURITY NO <i>579-48-7599</i>			17 INFORMANT (AUNT) <i>Lige Moffett, Ching Chuan</i>			Address <i>4856 Ching Chuan Blvd.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>												2 months					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i>												8 years					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes</i>																	
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State											
22a I certify that (I) (this hospital) attended the deceased from <i>Oct 10, 1968</i> to <i>1/19, 1969</i> , that (I) (we) last saw the deceased alive on <i>1/19, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <i>Dr Joseph P. Kenrick</i>			DEGREE <i>MD</i>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <i>1/19/69</i>								
22a. PHYSICIAN'S NAME (Type) <i>Dr JOSEPH P. KENRICK</i>			22e ADDRESS <i>6450 Wisconsin Ave, Bethesda, Md.</i>														
23a BURIAL, CREMATION, OR DISPOSAL (Specify) <i>Burial</i>			23b DATE <i>1-22-1969</i>			23c NAME OF CEMETERY OR CREMATORY <i>St. Thomas Church Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Croon, Maryland</i>								
24 FUNERAL DIRECTOR <i>Joseph H. Lawler's Son, Inc., Wash, D.C.</i>			ADDRESS <i>30 W. 14th St., N.W.</i>			25a REC'D BY REGISTRAR <i>JAN 24 1969</i>			25b REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item 7 Film 408 1/14/69 kk												
1. DECEASED-NAME (Type or print) Florence M. Seally						2a. DATE OF DEATH Month Jan Day 1 Year 1969			2b. HOUR 3:30 AM			
3 SEX F		4. RACE Caucasian		5. DATE OF BIRTH 8/31/84			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.D.			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 801 Lyford Terr.		
14. FATHER'S NAME First John Middle Athoff Last Blair			15. MOTHER'S MARDEN NAME First Mary Middle Blair Last Blair									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 074-20-7540			17. INFORMANT Mrs. Emeline C. Dickson			Address Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral metastasis DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic carcinoma Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 1 Year		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1968 , to Jan 1, 1969 , that (I) (we) last saw the deceased alive on January 1, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Raymond Bradshaw, MD						DEGREE MD			22c. DATE SIGNED Jan 1, 1969			
22d. PHYSICIAN'S NAME (Type) Raymond Bradshaw						22e. ADDRESS 345 University Blvd, W. Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-3-69			23c. NAME OF CEMETERY OR CREMATORY Long Island National			23d. LOCATION (City or Town) (County) (State) Farmingdale New York			
24. FUNERAL DIRECTOR Francis J. Hallis			ADDRESS 500 University Blvd, Silver Spring, Md.			25a. REC'D BY REGISTRAR JAN 6 1969			25b. REGISTRAR'S SIGNATURE J. Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1222												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												966-6400											
1 DECEASED-NAME (Type or print) First Middle Last												2a DATE OF DEATH Month Day Year												2b HOUR											
CURT C. Schiffeler												1-21-69												5:30 PM											
3 SEX				4 RACE				5 DATE OF BIRTH				6 AGE (in years last birthday)				7 UNDER 1 YEAR MONTHS DAYS				7 UNDER 24 HRS HOURS MIN															
MALE				White				6-5-92				76 YRS.																							
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH																							
Germany				U.S.A.								Montgomery																							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY																							
Bethesda				Suburban				Retired - MANAGER				HOTELS																							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER																			
Md.				Montgomery				Chevy Chase				YES				2 Farmington Drive																			
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last																															
CARL				Schiffeler				MARIA				SEITZ				SEITZ EDD.																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b SOCIAL SECURITY NO				17 INFORMANT Address																											
No				579-01-7008				Mrs. Mary Schiffeler				2 Farmington Dr.																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestion and edema, pulmonary																																			
41																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																			
(b) Hypertensive cardiovascular disease																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
Associated with GI hemorrhage due to peptic ulcers																																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State																											
22a I certify that (I) (this hospital) attended the deceased from 1955 to Jan. 21, 1969, that (I) (we) last saw the deceased alive on Jan. 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b SIGNATURE																																			
Geo. A. Gray, Jr. MD																																			
22c DATE SIGNED																																			
1/21/69																																			
22d PHYSICIAN'S NAME (Type)																																			
Geo. A. GRAY JR MD																																			
22e ADDRESS																																			
4740 Chevy Chase Drive, Chevy Chase, Md. 20911																																			
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)																							
Removal				1-24-1969				Cedar Hill Cemetery				Newark, Ohio																							
24 FUNERAL DIRECTOR																																			
Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016																																			
25a REC'D BY REGISTRAR												25b REGISTRAR'S SIGNATURE																							
JAN 29 1969												Charles Judge																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

01234		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01225	
1. DECEASED NAME (Type or print) <i>Minna A. Schoenfeld</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>9</i> Year <i>69</i>		2b. HOUR <i>9:45</i> PM
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>2/3/89</i>		6 AGE (In years last birthday) <i>79</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Germany</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i> Md.		
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>RETIRED</i>	
13a USUAL RESIDENCE (Where deceased last lived, if institution residence before admission) STATE <i>MARYLAND</i>		13b COUNTY <i>MONTGOMERY</i>	13c CITY OR TOWN <i>Silver Spring</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>120 FLEETWOOD TERRACE</i>
14 FATHER'S NAME First Middle Last <i>Solomon Wolf</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Juhin OTTENBERG</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	17 INFORMANT Address <i>ERNEST SCHOENFELD - Son</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 7103 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>year</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-8</i> , 19 <i>69</i> , to <i>1-9</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>1-9</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Robert R. Montgomery</i>				22c DATE SIGNED <i>1-10-69</i>	
22d PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>				22e ADDRESS <i>5411 CEDAR LANE BETHESDA, MD.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Jan. 12, 1969</i>	23c NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon</i>		23d LOCATION (City or Town) (County) (State) <i>Hyattsville, Md.</i>
24 FUNERAL DIRECTOR <i>Bernard Danzansky & Sons</i>			25a RECEIVED BY REGISTRAR <i>3501 14th St. NW</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

INSTRUMENT C

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

51227

1. DECEASED-NAME (Type or print) FRANCES			First Middle Last			2a. DATE OF DEATH JAN Month 14 Day 69 Year			2b. HOUR 11:20 P.M.		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 2/7/12			6. AGE (In years last birthday) 56 YRS.		
7a. BIRTHPLACE (State or foreign country) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY Pr. Geo's			13c. CITY OR TOWN BOWIE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 7 Pine Ridge Rd.			14. FATHER'S NAME Unknown			15. MOTHER'S MAIDEN NAME Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Frederick Schwarze			Address Bowie, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aortic stenosis, insufficiency, mitral DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic heart disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Respiratory infection											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/5/69 , 19 69 , to 1-14 , 19 69 , that (I) (we) last saw the deceased alive on 1-14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Fidel J. Quintana</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1-14-69		
22d. PHYSICIAN'S NAME (Type) FIDEL J. QUINTANA						22e. ADDRESS 8715 FIRST AVE, S. SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan 21, 1969			23c. NAME OF CEMETERY OR CREMATOR Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland.		
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Md.			25a. REC'D BY REG. STAFF JAN 21 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2c DATE OF DEATH Month Day Year		
William			Scott						January 30, '69		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE in years last birthday		2b HOUR		
Male		White		11-3-'83			85 YRS.		9:40 A.M.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Iowa			U. S. A.					Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Colonial Villa Nursing Home			Mail Carrier			U.S.A.		
13a U.S. RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md-			Montgomery			Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		3002 Medway St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Silas			Scott			Susan			Rogers		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
no			504-22-9371			Marguerite			3002 Medway St - Wheaton, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>known CVA</u>											
4369 DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Generalized atherosclerosis and CVA</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>CVA infection + old bleeding duodenal ulcer</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>58</u> , to <u>30 Jan</u> , 19 <u>69</u> , that (1) (we) last saw the deceased alive on <u>30 Jan</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE											
Eugene J. Chap M.D.											
22c DATE SIGNED											
30 Jan 69											
22d. PHYSICIAN'S NAME (Type)											
Eugene J. Chap											
22e. ADDRESS											
1302 18th St. N.W. WASHINGTON, DC											
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/1/69		Ft. Lincoln Cemetery			Prince Georges Co. Md.			
24 FUNERAL DIRECTOR											
The S.H. Kline Co. 2901 14th St. N.W.											
25a REC'D BY REG STRAR											
25b REGISTRAR'S SIGNATURE											
FEB 3 1969											

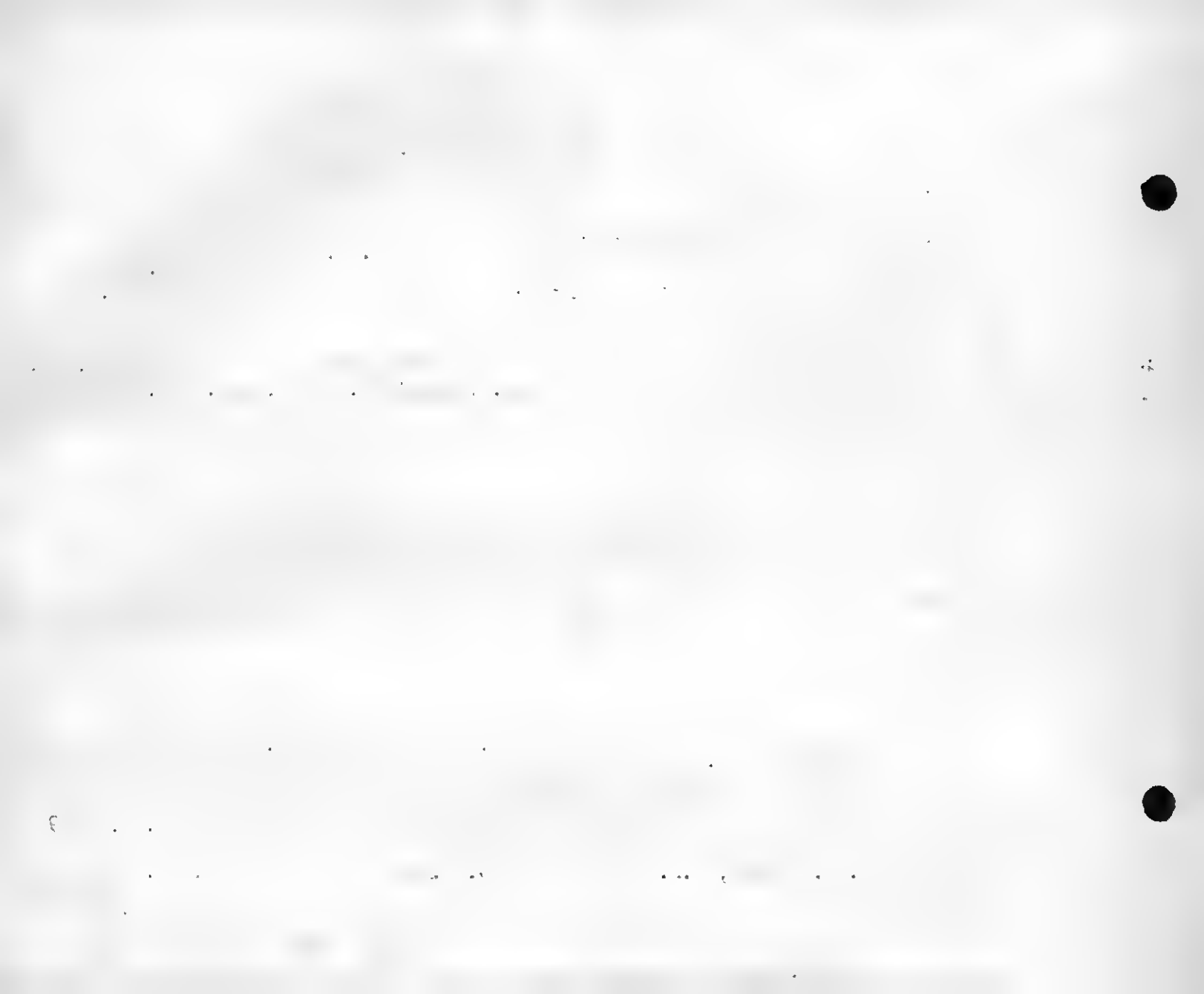
513
A. 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
Item: 23h, Film 3408 1/20/69 km			-1229							
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH	
Lister							Sells		January Month 7 Day 1969 Year	
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)	
Male			Caucasian			April 16, 1907			61 YRS	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Ohio			USA						Montgomery Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Navy				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS OF CITY LIM-757	
Virginia			Arlington			Arlington			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last			13e STREET AND NUMBER			Apt. 867	
Charles Sells									1200 North Nash St.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address	
Yes						Nash Street			Arlington, Va.	
						Mrs. Virginia D. Sells, Apt. 867, 1200 North				
18 CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac and Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema + pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTR. BLTING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BLTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A M P.M. Month Day Year 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21c LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from Dec. 13, 1968, to Jan. 7, 1969, that (X) (we) last saw the deceased alive on Jan. 7, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death										
22b SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED	
C. S. CRUMMY, M.D.									Jan. 7, 1969	
22d PHYSICIAN'S NAME (Type)			22e ADDRESS							
			Naval Hospital, Bethesda, Md.							
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)	
Burial			1/10/69			Arlington National Cemetery			Arlington, Virginia	
24 FUNERAL DIRECTOR			25a RECEIVED BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Ives Funeral Home			JAN 14 1969			[Signature]				
2847 Wilson Blvd. Arlington, Virginia			DATE							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 2a Film 409 Maryland State Department of Health
2-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) Kenneth Wayne Santelle			2a. DATE KNOWN OF DEATH Month 1 Day 1 Year 1969			2b HOUR 8:15 PM			
3 SEX male	4 RACE white	5 DATE OF BIRTH 10-26-46	6 AGE (In years last birthday) 22 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD Month 1 Day 1 Year 1969			2d HOUR 8:15 PM
7a BIRTHPLACE (State or foreign country) Penn		7b CITIZEN OF WHAT COUNTRY? American		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Tolome Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shannon Hospital		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Belt		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1420 Univ Blvd	
14. FATHER'S NAME First Middle Last Duard L Santelle			15. MOTHER'S MAIDEN NAME First Middle Last Joan Hottle						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service) none		17 INFORMANT Duard L Santelle		ADDRESS Hyattsville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia, bilateral, and 401X DUE TO, OR AS A CONSEQUENCE OF (b) acute right pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN K. REAP		22b. DATE SIGNED JAN. 1, 1969		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE Jan 4, 1969		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.	
25a REC'D BY REGISTRAR JAN 6 1969		25b REGISTRAR'S SIGNATURE J. Charles Judge							



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) <i>Mattie E. Jettson</i>			2a DATE KNOWN OF DEATH ESTI <input checked="" type="checkbox"/> Month Day Year <i>Jan 23 1969</i>			2b HOUR <i>3:30 PM</i>					
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Oct. 9, 1876</i>	6 AGE (In years last birthday) <i>92</i> YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <i>Jan 23 1969</i>			2d HOUR <i>3:30 PM</i>		
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Mo.		
10 CITY OR TOWN OF DEATH <i>Rockville</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) <i>Suburban Housekeeper</i>			12a USUAL OCCUPATION (Kind of work done during most of work ng life even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Mont. Co</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>15 Wall Street.</i>			
14 FATHER'S NAME First Middle Last <i>Leem Sexton</i>				15 MOTHER'S MAIDEN NAME First Middle Last <i>Mary Ellen Sexton</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO <i>213-56-2188</i>			17 INFORMANT ADDRESS <i>Wall St. 15 Rockville Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia. Bronchial.</i>										<i>48 hrs</i>	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <i>Fracture. Rt Humerus. Impacted.</i>										<i>17 days</i>	
(c) <i>Cardio Vascular Disease - Generalized Sclerosis years.</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year <i>Jan 6 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fall at Home -</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>15 Wall St.</i>		City or Town <i>Rockville</i>		County <i>Montgomery</i>		State <i>Md.</i>	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>Jan 23, 1969</i>			
EXAMINER'S NAME (Type) <i>John G. Ball</i>				ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>							
23a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>1-26-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillside Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hillside Rockton Virginia</i>					
24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>				ADDRESS <i>7557 1/2 Wisconsin Rd Bethesda Md</i>				25a. REC'D BY REG STRAR DATE <i>JAN 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Shaw			2a. DATE OF DEATH Month Day Year 1-15-69			2b. HOUR 3:15 AM	
3 SEX Female		4 RACE white		5. DATE OF BIRTH 1-15-69		6. AGE (In years last birthday) YRS. MONTHS DAYS 1 15 3	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (admission) STATE Md.		Where deceased lived, if institution: Residence before 13b. COUNTY mont.		13c. CITY OR TOWN Silver Sp		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last David Whitmore Shaw		15. MOTHER'S MAIDEN NAME First Middle Last Eleanor Julia Niciewsky					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 1 lb 2 g 777X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Francis A. Ostmann, Jr.				22c. DATE-SIGNED 1/17/69		22d. PHYSICIAN'S NAME (Type) Francis A. Ostmann, Jr.	
22e. ADDRESS 800 Pershing Drive, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/22/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler				1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR JAN 27 1969	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL ☒ ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01233											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <i>Laverna Sherer</i>						2a. DATE OF DEATH Month Day Year <i>Jan. 6, 1969</i>			2b. HOUR <i>3:15 P.M.</i>		
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>12/31/85</i>		6. AGE (In years last birth) <i>83</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban House Wife</i>				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>private</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kennington</i>		13d. INSIDE CITY L.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5316-Banger Drive</i>	
14. FATHER'S NAME First Middle Last <i>Fernando Skinkle</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth Convey</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>				16b. SOCIAL SECURITY NO. <i>273-34-9766</i>		17. INFORMANT Address <i>Ruth Convey - daughter</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 41- } DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Coronary Arteriosclerosis - acute</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-6</i> , 1968, to <i>1-6</i> , 1968, that (I) (we) saw the deceased alive on <i>1-6</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>D.C. Bucy</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1-6-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>D.C. Bucy</i>						22e. ADDRESS <i>809 Veirs Mill Rd Rockville Md.</i>					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
<i>Bur-Transit</i>		<i>1/9/69</i>		<i>Mt. Hill</i>				<i>Eaton, Ohio</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home 1331 Rock. Pike</i>						25a. REC'D BY REGISTRAR <i>JAN 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
<i>Rockville, Maryland</i>											

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1234

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR	
Sylvia I. Sherman						MATED <input type="checkbox"/> Jan 5, 1969						6:20 PM	
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR	
Female	cau	4/12/00	68 YRS	MONTHS	DAYS	Jan. 5 1969						6:20 PM	
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Virginia		U.S.				Montgomery			Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Holy Cross Hosp			Housewife			own home				
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS			13e. STREET AND NUMBER	
Maryland			Montgomery			Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13315 Vandalia Dr.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Fullen			--		Kiser	Mary					Catherine	Deane	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
			234 42 0898			Vola V. Adams			1503 Windham La.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State		
22a. I certify that I took charge of the remains described above held on death resulted from													
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS			JAN. 5, 1969				
Belden R. Reap			M.D.			Rockville Montgomery Md.							
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			1-9-1969			Parble Cemetery			Rockville Montgomery Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
C. Gle. Carter			Sil. Spr., Md.			JAN 13 1969			Charles Judge				

CLEARED BY DR. REAP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>Item 11 Film 009</div> <div>2/19/69 kk</div> <div>01233</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01235</div>									
1 DECEASED-NAME (Type or Print) First Middle Last William S Simmons						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1 31 19 69		2b HOUR 11:58 PM	
3 SEX Male	4 RACE Cauc	5 DATE OF BIRTH 6/17/45	6 AGE (In years last birthday) 23 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year 2 1 19 69		2d HOUR 12:10 PM	
7a BIRTHPLACE (State or foreign country) s Maine		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		Md.	
10 CITY OR TOWN OF DEATH Silver Spring Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Mont.		13c CITY OR TOWN Sil. Spg.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 10109 Portland Pl.	
14. FATHER'S NAME First Middle Last Roy Stewart Simmons				15 MOTHER'S MAIDEN NAME First Middle Last Martha Pearl Phillips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service) 217-44 5917		17 INFORMANT mother ADDRESS Mrs. Pearl Barnes 10109 Portland Pl.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) incurred in auto accident. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 11:30 AM 1-31 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver was proceeding in car which struck tree					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) Street		21f LOCATION Street or R.F.D. No Norbeck Rd, Silver Spring		City or Town Montg.		State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Read		EXAMINER'S NAME (Type) BELDEN R. READ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Feb. 1, 1969			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 3, 1969		23c NAME OF CEMETERY OR CREMATORY Parklawn		23d LOCATION (City or Town) (County) (State) Rockville, Montgomery Md.			
24. FUNERAL DIRECTOR Paul J. Smith Warner E. Pumphrey Inc. 8434 Gt. Ave. Silver Spring, Md.				25a REC'D BY REGISTRAR FEB 5 1969		25b. REGISTRAR'S SIGNATURE William E. Yager			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Catherine A. Simon</i>			2a. DATE OF DEATH Month <i>Jan.</i> Day <i>3</i> Year <i>1969</i>			2b. HOUR <i>8:15</i>	
3 SEX <i>F</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-23-59</i>		6. AGE (in years last birthday) <i>9</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Spain</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland Mont.</i>		13c. CITY OR TOWN <i>Facetsville</i>		13d. INS. DE. CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>12008 Hyperneth Lane</i>	
14. FATHER'S NAME First <i>Robert</i> Middle <i>Simon</i> Last <i>Simon</i>			15. MOTHER'S MAIDEN NAME First <i>Barbara M.</i> Middle <i>Stern</i> Last <i>Stern</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>No.</i>		17. INFORMANT Name <i>Mrs. Barbara M. Stern</i> Address <i>Silver Spring</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cerebral edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Encephalitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Varicella viremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>052 X</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>43 hrs.</i> <i>4 DAYS</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/1</i> , 19 <i>69</i> , to <i>1/3</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/3</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Henry W. Stout</i>				22c. DATE SIGNED <i>1/3/69</i>		22d. PHYSICIAN'S NAME (Type) <i>HENRY W. STOUT</i>	
23a. BURIAL CREMATION, etc. (Specify) <i>Burial</i>		23b. DATE <i>1/6/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Beallsville, Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>				25a. REC'D BY REGISTRAR <i>IAN 7 1969</i>		25b. RECORD SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First HARRISON	Middle ARTHUR	Last SMALL	2a. DATE OF DEATH Month 1 / Day 1 / Year 69		2b. HOUR 9:21 P.M.		
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 11/22/88		6. AGE (in years last birthday) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md.			
10 CITY OR TOWN OF DEATH OLNEY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) RETIRED ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN CLARKSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER TROTTER ROAD	
14 FATHER'S NAME First Middle Last PURINTON SMALL		15. MOTHER'S MAIDEN NAME First Middle Last JANE POWERS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO (If yes give war or dates of service) NOT KNOWN		17 INFORMANT MEDICAL RECORDS		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 in 1</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular accident, three days									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (the physician) attended the deceased from 2/26/1958, to 1/1/1969, that (I) (we) last saw the deceased alive on 1/1/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles S. Whitaker, M.D.		22c. DATE SIGNED 1/3/69		22d. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.					
22e. ADDRESS Ten Oaks Road Clarksville, Maryland 21029									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN 3, 1969		23c. NAME OF CEMETERY OR CREMATORY LEE Funeral Home		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.			
24. FUNERAL DIRECTOR Higinbotham Slack		ADDRESS ELLICOTT ST. and		25a. REC'D BY REGISTRAR DATE 7 1969		25b. REGISTRAR'S SIGNATURE William A. Venable			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Daniel Lott Smith						2a. DATE OF DEATH Month 1 Day 13 Year 69			2b. HOUR M			
3 SEX Male		4. RACE Negro		5. DATE OF BIRTH 3/20/1892			6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Candor, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nurs. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Janitor			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Washington, DC			13b. COUNTY MD			13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 35 Shepherd St		
14. FATHER'S NAME First Middle Last Archie Smith				15. MOTHER'S MAIDEN NAME First Middle Last ? Laura A. Johnson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give year or dates of service) WWI				16b. SOCIAL SECURITY NO		17. INFORMANT Address Martha Smith -1335 Shepherd St., NE-Wife						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Coronary Atherosclerosis												
DUE TO, OR AS A CONSEQUENCE OF												
(b) Myocardial Infarction												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Arteriosclerosis												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1-2-69 , 19 69 , to 1-13-69 , 19 69 , that (I) (we) last saw the deceased alive on 1-12-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE (Signature)						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-13-69				
22d. PHYSICIAN'S NAME (Type) Dr. T. Carreno						22e. ADDRESS 6101 New Hampshire Ave., NE, Wash., DC						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-17-69			23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Clinton, Maryland			
24. FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 12th Street, N. E.						25a. REC'D BY REGISTRAR JAN 17 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 12, 13 & 15 filled in
2/21/69 kk 3124

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11200

1 DECEASED-NAME (Type or print) First Middle Last Martin Luther Smith			2a. DATE OF DEATH Month Day Year 1 13 69		2b. HOUR 9:40 AM
3 SEX MALE	4. RACE White	5. DATE OF BIRTH MARCH 13, 1881		6. AGE (In years last birthday) 87 YRS.	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.		
1d. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAND HOSP.		12a. USIA. OCCUPATION (Kind of work done during most of working life even if retired) TEXTILE WORKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8413 4TH AVE.	
14 FATHER'S NAME First Middle Last RUSUS Smith		15. MOTHER'S MAIDEN NAME First Middle Last Clermatine Olemire Kallam KeMum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 243-34-4322		17. INFORMANT Address Patients Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Ca of Prostate DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 12/31		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Prostate		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1968 , to 1/13, 1969 , that (I) (we) last saw the deceased alive on 1/11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Walter Bloom		22c. DATE SIGNED 1/13/69		22d. PHYSICIAN'S NAME (Type) Walter Bloom	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Overlook Cemetery	
23d. LOCATION (City or Town) (County) (State) Eden		23e. REC'D BY REGISTRAR JAN 16 1969		23f. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

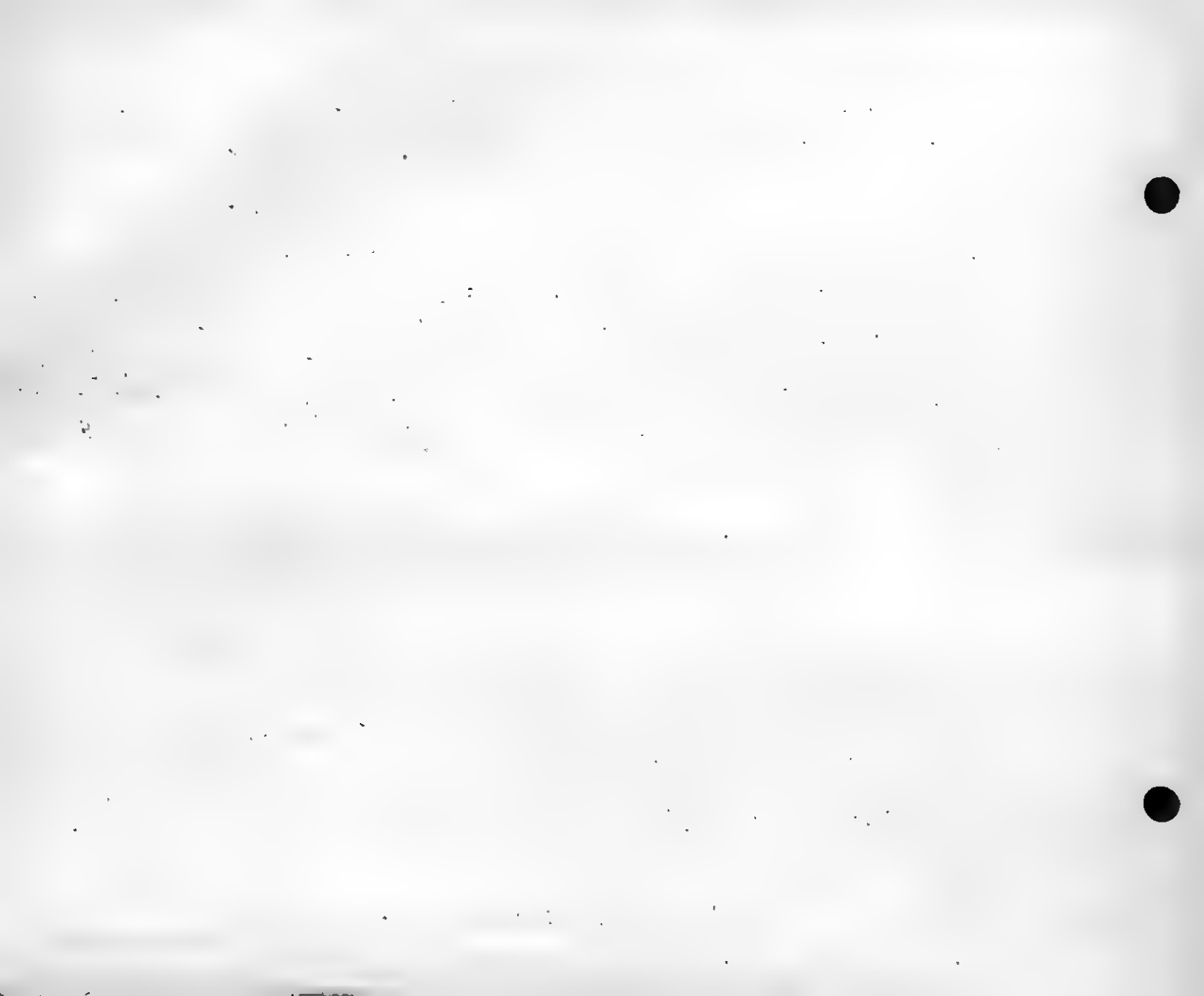
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01245

01240

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Sadie E Smith</i>			2a. DATE OF DEATH Month <i>January</i> Day <i>20</i> Year <i>69</i>			2b. HOUR <i>7:35 P.M.</i>	
3 SEX <i>F</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>9-25-08</i>		6 AGE (In years last birthday) <i>60</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Emp Smith Inc</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>19 C</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>3560 Brandepine St NW</i>		14. FATHER'S NAME First <i>Paul</i> Middle <i>Edgar</i> Last <i>Smith</i>		15. MOTHER'S MAIDEN NAME First <i>Beatrice</i> Middle <i>Stein</i> Last <i>Stein</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>577-347758</i>		17. INFORMANT <i>Stephen R Grayson</i>		Address <i>5304 Ridgefield Rd Bethesda, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY <i>4334</i> IMMEDIATE CAUSE (a) <i>Cerebral infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>10 Jan 1969</i> to <i>20 Jan 1969</i> , that (I) (we) last saw the deceased alive on <i>20 Jan 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert A. Mendelsohn MD</i>				22c. DATE SIGNED <i>1/20/69</i>		22d. PHYSICIAN'S NAME (Type) <i>ROBERT A. MENDELSON</i>	
22e. ADDRESS <i>1015 Spring St. S.E. Wash D.C.</i>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>1/22/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WASH. HEBREW Cong. Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>WASH. D.C.</i>	
24. FUNERAL DIRECTOR <i>B. DANZANSKY & SONS</i>		ADDRESS <i>3501-14th St. N.W. WASH D.C.</i>		25a. REC'D BY REG. STRAR <i>JAN 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1224

1 DECEASED NAME (Type or print) First Middle Last Edward H. Soumelle 2a DATE OF DEATH Month Day Year 1-1-69 2b HOUR 9:12 M

3 SEX MALE 4 RACE WHITE 5 DATE OF BIRTH 12-1-1886 6 AGE (n years last birthday) 82 YRS 7 UNDER 1 YEAR MONTHS 8 UNDER 24 HRS HOURS 9

7a BIRTHPLACE (State or foreign country) Chicago, Ill. 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 COUNTY OF DEATH MONTGOMERY Md

10 CITY OR TOWN OF DEATH KENSINGTON 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Nursing Home - Gen. MIAMI Sup. 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gen. Motors 12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admiss on) STATE 13b COUNTY 13c CITY OR TOWN 13d ASIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET AND NUMBER 13f APARTMENT, BUILDING, OR UNIT 13g ZIP CODE 13h COUNTRY

14 FATHER'S NAME First Middle Last Jacob SOMMER 15 MOTHER'S MAIDEN NAME First Middle Last MARY PETERS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No 16b SOCIAL SECURITY NO 380-109-188 17 INFORMANT (Name) Address, Rockville, Md. Donald SOMMER, 9812 Old Gate Rd.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis 4397 DUE TO, OR AS A CONSEQUENCE OF 1 week
Conditions, if any, which gave rise to immediate cause (a) (b) Cerebral Arteriosclerosis 3 years
stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus, Carcinoma of Prostate

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While ☐ Not while ☐ at work ☐ 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 21f LOCATION Street or RFD No City or Town County State

22a I certify that (I) (the hospital) attended the deceased from April 4, 1966, to Jan. 1, 1969, that (I) (we) last saw the deceased alive on Dec. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE C.R. Gruver M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c DATE SIGNED Jan. 1, 1969

22d PHYSICIAN'S NAME (Type) Clifton R. Gruver 22e ADDRESS 915 19th St. N. W. Wash. D. C.

23a BURIAL, CREMATION, or other disposition of body Burial - Transit 23b DATE 1/4/1969 23c NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery 23d LOCATION (City or Town) (County) (State) Hillside Ill.

24 FUNERAL DIRECTOR 1331 Rockville Pike Tyson Wheeler Funeral Home Rockville, Md 25a REC'D BY REGISTRAR JAN 6 1969 25b REGISTRAR'S SIGNATURE Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0124.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01242

1 DECEASED-NAME (Type or Print) First Middle Last Thelma Spinello			2a DATE KNOWN OF DEATH Month Day Year 1-15 69		2b HOUR 2:30 PM
3 SEX F	4 RACE W	5. DATE OF BIRTH 4-30-21	6 AGE (In years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS DAYS 47	IF UNDER 24 HRS HOURS MIN. 47
7a BIRTHPLACE (State or foreign country) New Jersey		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c DATE PRONOUNCED DEAD Month Day Year Jan 15 19 69		9 COUNTY OF DEATH Montgomery		9d HOUR 2:30 PM	
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE New Jersey		13b COUNTY Kearny		13c STREET AND NUMBER 674 Forest St.	
14 FATHER'S NAME First Middle Last Frank Appleman			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO No		17 INFORMANT Gerald Spinello	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism 816.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR AM/PM 7:00 PM 1-1 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 (Item 18). Deceased was a passenger in auto when driver lost control and ran off road	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No City or Town County State Prince Geo. Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED JAN. 15, 1969	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1-18-69		23c NAME OF CEMETERY OR CREMATORY Holy Cross	
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 500 Union Blvd. E. of Sp. Rd.		25a. REC'D BY REGISTRAR DATE JAN 20 1969	
				25b. REGISTRAR'S SIGNATURE Francis J. Collins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove coroner's pages 1 and 2 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (4)
30M REV 11/66

MIDDLE										LOST										20. DATE OF DEATH										2b HOUR																																																	
1. DECEASED-NAME (Type or print) EDWARDS STACY										4. RACE CAUS.										5. DATE OF BIRTH 2/22/1880										6. AGE (In years last birthday) 88										7. MONTH JAN										8. DAY 23										9. YEAR 1969										10. 2b HOUR 7:15 PM									
3. SEX MALE										7a. BIRTHPLACE (State or foreign country) AMELIA VA.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH MONTGOMERY										10. MD.																													
10. CITY OR TOWN OF DEATH WHEATON										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) OWNER OF PLUMBING BUS										12b. KIND OF BUSINESS OR INDUSTRY																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MD.										13b. COUNTY MONTGOMERY										13c. CITY OR TOWN SILVER SPRING										13d. INSIDE CITY LIMITS? YES										13e. STREET AND NUMBER 2105 Seminary Rd.																																							
14. FATHER'S NAME First Cephas Middle Neale Last Stacy										15. MOTHER'S MAIDEN NAME First Emma Middle Cora Last Edwards										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO. 229-60-0099										17. INFORMANT Earle M. Stacy - 2105 Seminary Rd. Sil. Spg Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4369 IMMEDIATE CAUSE (a) Probable Cora Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from Jan 22, 1969 , to Jan 23, 1969 , that (I) (we) last saw the deceased alive on Jan 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE Russell C. Bufalino										22c. DATE SIGNED Jan 24, 69										22d. PHYSICIAN'S NAME (Type) Russell Bufalino, M.D.										22e. ADDRESS 1429 University Blvd. West, Sil. Spr., Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE Jan 27, 1969										23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery										23d. LOCATION (City or Town) (County) (State) Suitland, Maryland																																																	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.										24a. ADDRESS 8434 Georgia Avenue										24b. REC'D BY REG. STRAR JAN 29 1969										24c. REGISTRAR'S SIGNATURE Charles Judge																																																	

CERTIFICATE OF DEATH

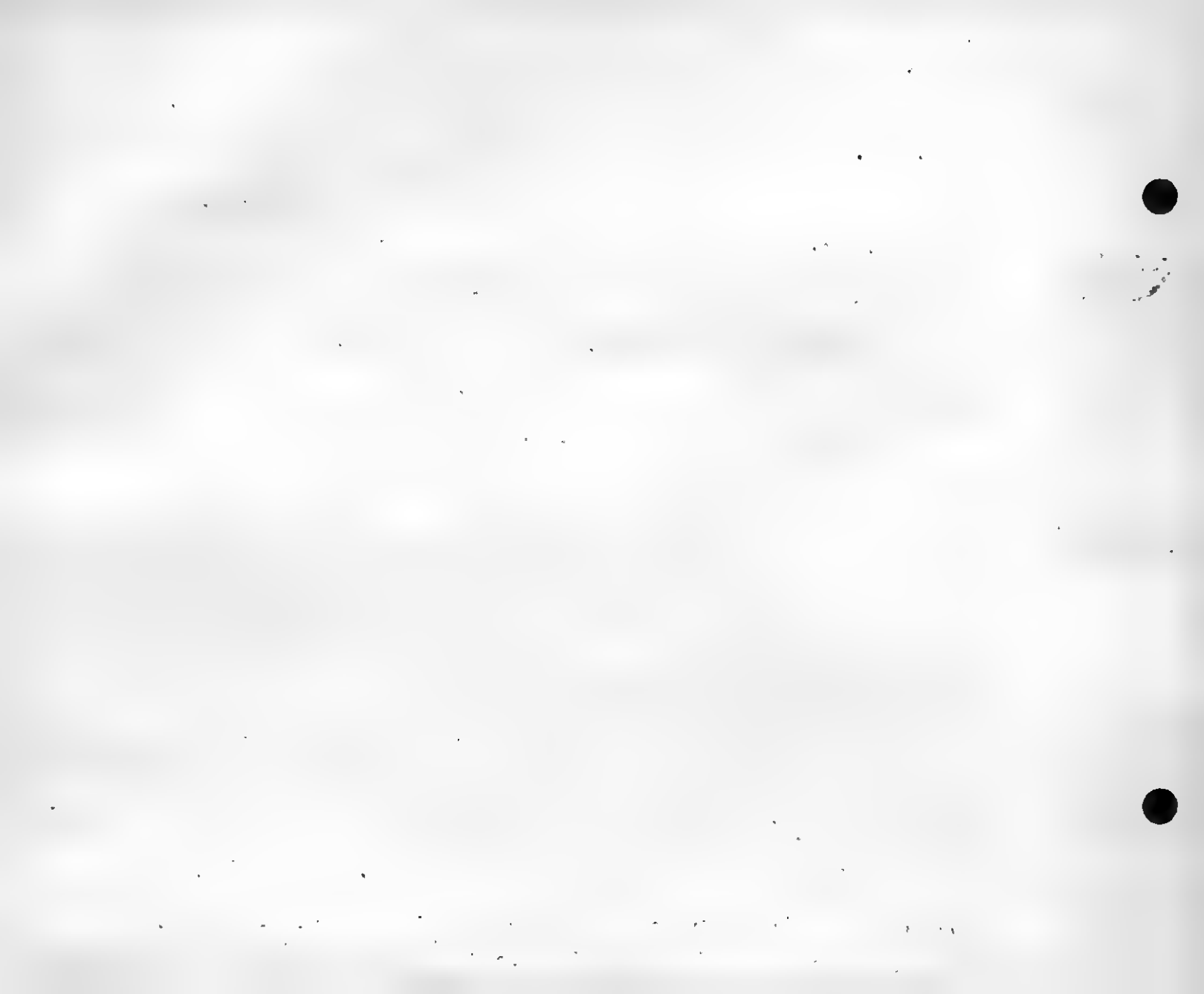
21240

1244

1 DECEASED NAME (Type or print) <i>TWIN I</i>			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
<i>male</i>			4 RACE <i>Wh.</i>			5. DATE OF BIRTH <i>11/13/69</i>			6 AGE (In years last birthday) YRS. MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>montgomery</i> Md.		
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md</i> COUNTY <i>P.G.</i>			13c CITY OR TOWN <i>Greenbelt</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>14H. Ridge Rd.</i>		
14. FATHER'S NAME <i>Hapevey Robert Stanley</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Mollie Edith Batson</i>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT <i>mother</i>			Address <i>As Above</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>IMMATUREITY</i> <i>11/13</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 hrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 13</i> , 19 <i>69</i> , to <i>Jan 14</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mitchell Woldoff M.D.</i>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>1/14/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Mitchell Woldoff</i>			M.D.			22e. ADDRESS <i>9801 Georgia Ave Silver Sp, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>1-16-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>			23d. LOCATION (City or Town) (County) (State) <i>SILVER SPR MONT MD</i>		
24. FUNERAL DIRECTOR <i>TYSON WHEELER</i>			ADDRESS <i>1331 ROCKVILLE RD ROCKVILLE MD</i>			25a. REC'D BY REGISTRAR <i>JAN 21 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

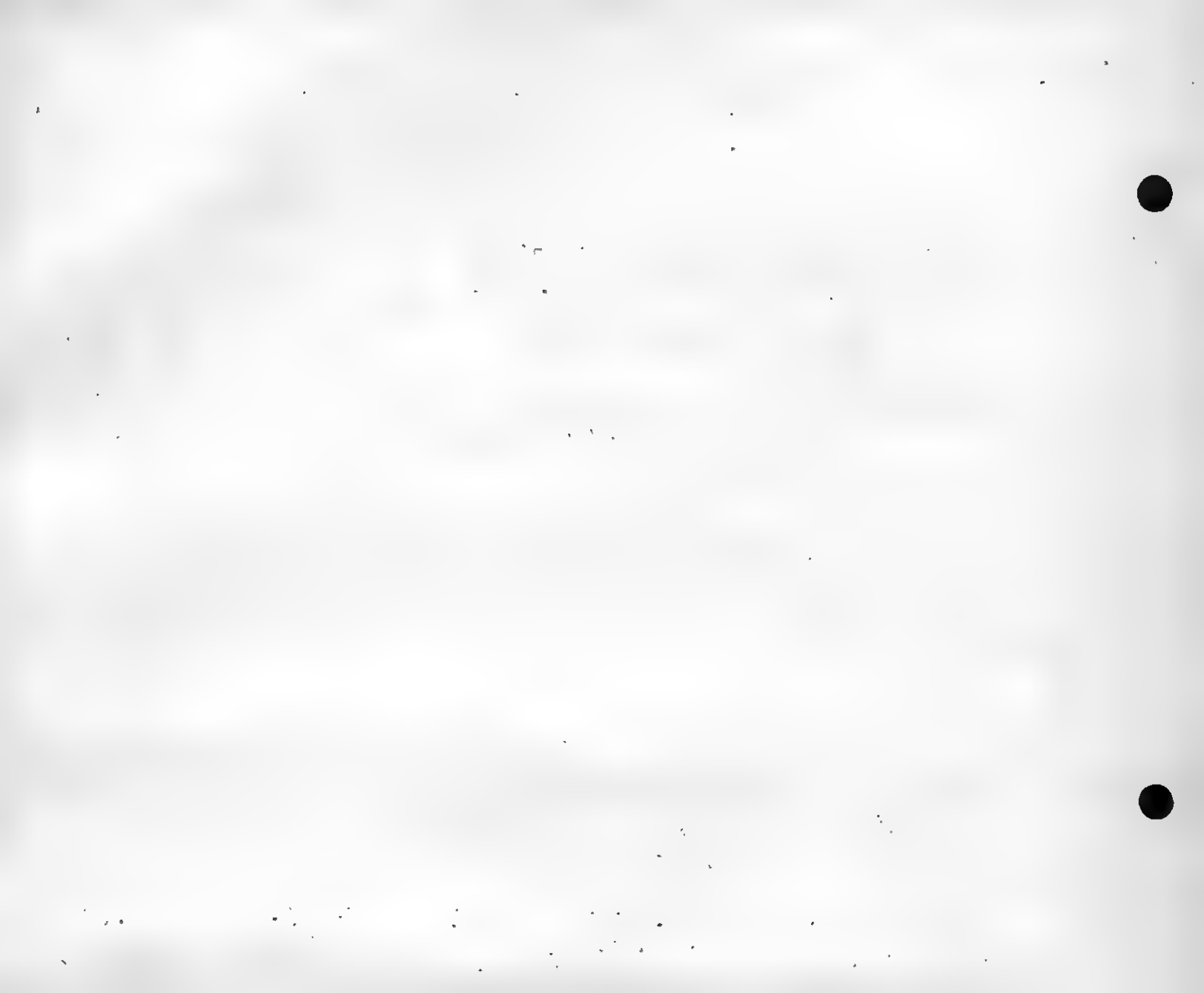


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

01245

1. DECEASED NAME (Type or print) "B" Girl.		First Middle Last		STANLEY		20. DATE OF DEATH		Month 14 Day 69 Year		2b. HOUR		8:15 M	
3. SEX F		4. RACE cauc.		5. DATE OF BIRTH 1-13-69		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14H L. Jye Rd.					
14. FATHER'S NAME First Middle Last Naerey Robert Stanley		15. MOTHER'S MAIDEN NAME First Middle Last Mollie Edith Batson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT mother AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 13 APR, 1969, to JUN 19, 1969, that (I) (we) last saw the deceased alive on JAN 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Mitchell Waldoff MD		DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.		22c. DATE SIGNED 1-14-69									
22d. PHYSICIAN'S NAME (Type) Mitchell Waldoff		22e. ADDRESS 9801 Georgia Ave S.S. Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-16-69		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) SIL SPR. MONT MD.		(County) (State)					
24. FUNERAL DIRECTOR TYSON WHEELER ROCKVILLE MD		ADDRESS 1331 K... AVENUE		25a. REC'D BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

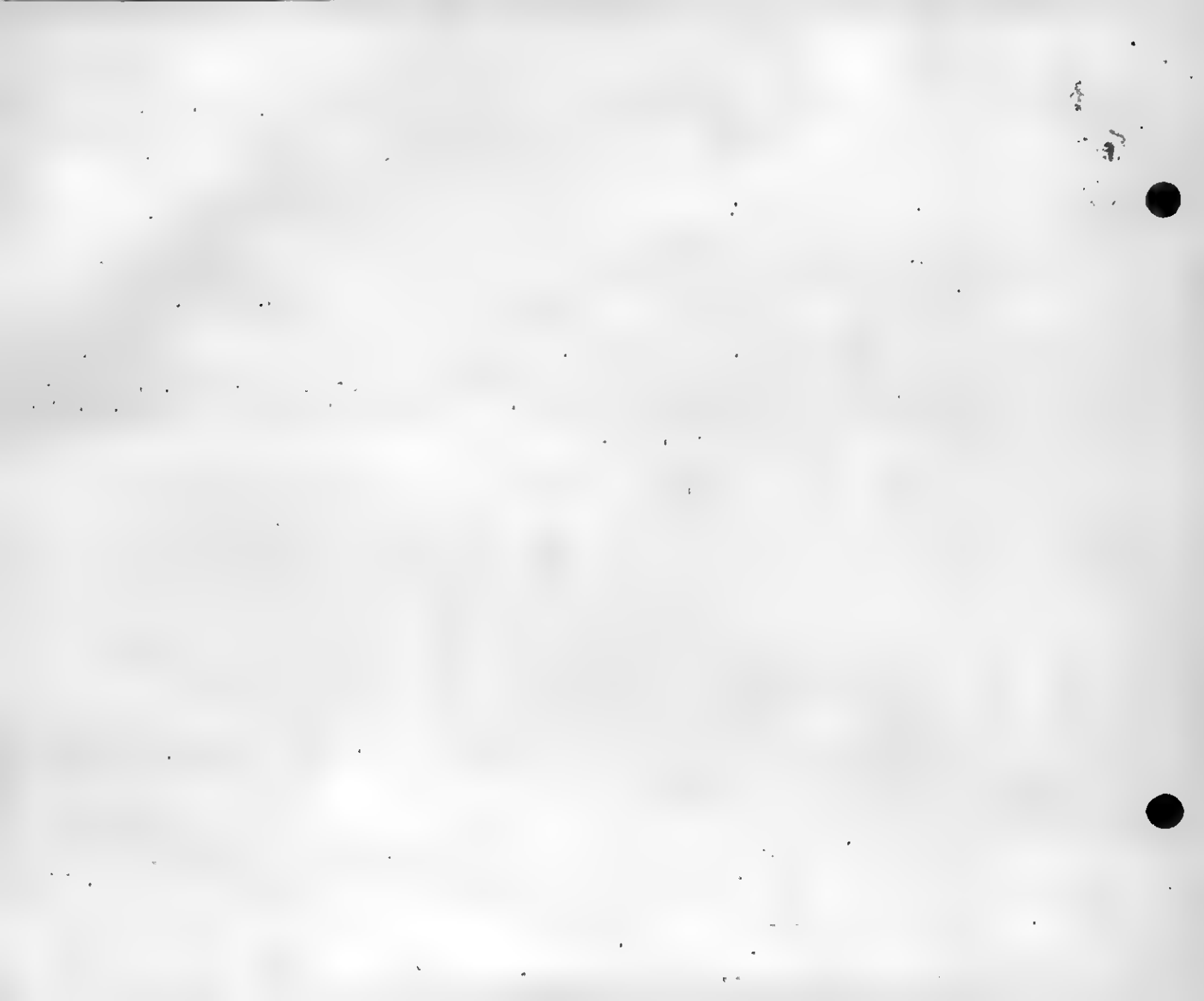


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;">First AliceMiddle (NMN)Last Stapleton</div>			2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;">Month JanuaryDay 29Year 1969</div>			2b HOUR 12:01 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 23 September 1950		6. AGE (In years last birthday) 18 YRS		IF UNDER 1 YEAR MONTHS 4 DAYS 7		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery County, Md					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH				12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE California		13b. COUNTY Montgomery		13c. CITY OR TOWN Atherton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2 Bassett Lane			
14 FATHER'S NAME <div style="display: flex; justify-content: space-between;">First ThomasMiddle C.Last Stapleton</div>			15 MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-between;">First HeleneMiddleLast Tinmmesen</div>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. Not Available		17 INFORMANT Address The Medical Records, National Institutes of Health, Clinical Center, Bethesda, Md. 20014							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>due to</u> DUE TO, OR AS A CONSEQUENCE OF <u>Burkitt's Lymphoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days 9 Months											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that XX (this hospital) attended the deceased from <u>2 January, 19 69</u> , to <u>29 January 19 69</u> , that XX (we) last saw the deceased alive on <u>29 January 19 69</u> , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) not view the body after death.											
22b. SIGNATURE <i>Sherrard L. Hayes MD</i>				DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 January 1969			
22d. PHYSICIAN'S NAME (Type) Sherrard L. Hayes, M. D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014							
23a. BURIAL, CREMATION, REMOVAL (Specify) XXXX		23b. DATE 2-4-69		23c. NAME OF CEMETERY OR CREMATORY Alta Mesa		23d. LOCATION (City or Town) Palo Alto		(County) California		(State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557-Wisconsin Ave., Bethesda, Md.						25a. REC'D BY REGISTRAR DATE FEB 3 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01251									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>Mildred Elizabeth Steinmetz</i>					2a. DATE OF DEATH Month Day Year <i>January 8, 1969</i>			2b. HOUR <i>12-15 P M</i>	
3 SEX <i>Female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>8/18/14</i>		6 AGE (in years lost birthday) <i>54</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery County</i> Md			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium & Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Credit Corp.</i>			
13a USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>		13b. if institut an Residence before <i>13b COUNTY</i> <i>Montgomery</i>		13c CITY OR TOWN <i>Wheaton</i>		13d. INSURE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>11426 Monterrey Drive</i>	
14 FATHER'S NAME First Middle Last <i>James P. Harkins</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Laurita ? Riley</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b SOCIAL SECURITY NO <i>140-03-2598</i>		17 INFORMANT <i>Hospital record</i>		Address <i>7600 Carroll Ave. Takoma Park, Md.</i>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis; Breast Cancer</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (th s hospital) attended the deceased from <i>Nov-10, 1968</i> , to <i>1/8, 1969</i> , that (I) (we) last saw the deceased alive on <i>Dec-1, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.									
22b SIGNATURE <i>John J. Merendino</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>1/8/69</i>			
22d PHYSICIAN'S NAME <i>JOHN J. MERENDINO, MD</i>				22e ADDRESS <i>11620 Kemp Mill Rd. Sil. Spgs. Md</i>					
23a BURIAL, CREMATION, <i>Burial</i>		23b. DATE <i>1/10/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Montg. Md</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>7557 Wisconsin Ave. Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>JAN 13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01253

01248

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Dorothy Virginia Stewart			2a. DATE OF DEATH Month January Day 16 Year 69			2b. HOUR 6:30 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 8-4-16		6. AGE (In years last birthday) 52 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTH PLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Takoma Pk.		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) Nash. San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Book keeper		12b. KIND OF BUSINESS OR INDUSTRY Freelance			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyatts.		13d. INSIDE CITY (Y/N) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6622 24th Plain	
14. FATHER'S NAME First Rowland Middle Darling Last Evans			15. MOTHER'S MAIDEN NAME First Annie Middle Evans Last Evans						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 098-14-3071		17. INFORMANT Pt's Chart		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 13, 1969 to Jan. 16, 1969 , that (I) (we) last saw the deceased alive on Jan. 16, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death									
22b. SIGNATURE G.B. Cushner MD				22c. DATE SIGNED 1-17-69					
22d. PHYSICIAN'S NAME (Type) G. B. Cushner		22e. ADDRESS White Oak, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 18, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01249

1. DECEASED NAME (Type or Print) <u>Centryde Joseph Stewart</u>			20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <u>1</u> Day <u>2</u> Year <u>1969</u> 2b HOUR <u>9:15A</u>		
3 SEX <u>female</u>	4. RACE <u>white</u>	5. DATE OF BIRTH <u>3-3-00</u>	6 AGE (In years last birthday) <u>78</u> YRS	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>
7a BIRTHPLACE (State or foreign country) <u>MD</u>	7b CITIZEN OF WHAT COUNTRY? <u>United States</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Montgomery</u> Md.		
10 CITY OR TOWN OF DEATH <u>Bethesda, D.C.</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Elizabeth's Hospital</u>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>At home</u>	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) "STATE" <u>MD</u>	13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Bethesda, D.C.</u>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <u>802 24th St NW</u>	
14. FATHER'S NAME First <u>Clark</u> Middle <u>Cooley</u> Last <u></u>			15. MOTHER'S MAIDEN NAME First <u>Harriet</u> Middle <u>West</u> Last <u></u>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT ADDRESS <u>Harvey J. Stewart, Husband, same as item #13</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4123 Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <u>19</u> HOURS <u>AM</u> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>	
22a. I certify that I took charge of the remains described above, held on death resulted from Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>JAN. 2, 1969</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town or County) <u>Leesburg, Virginia</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE <u>1-6-1969</u>	23c NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Leesburg, Virginia</u>	25a REC'D BY REGISTRAR <u>JAN 8 1969</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C. 20016</u>			25b REGISTRAR'S SIGNATURE <u>James Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
45M

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) Raymond T. Stout						2a. DATE OF DEATH Month JAN Day 17 Year 1969			2b. HOUR 5:52 A.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 12-3-87			6. AGE (In years last birthday) 81 YRS.		7. UNDER 1 YEAR MONTHS DAYS 		7. UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) KANSAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE W.C.				13b. COUNTY -		13c. CITY OR TOWN Washington		13d. INSIDE CITY, M.D.? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6124-30th St N.W.		
14. FATHER'S NAME First William T. Middle Last STOUT				15. MOTHER'S M.A.DEN NAME First SARAH Middle Last WARREN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO 578-60-9146		17. INFORMANT MRS. IVAL B. STOUT, WIFE, SAME AS 13				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, recent & remote												
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis with occlusion												
DUE TO, OR AS A CONSEQUENCE OF (c) 												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State 				
22a. I certify that (I) (this hospital) attended the deceased from 1-4 , 19 65 , to 1-17 , 19 67 , that (I) (we) last saw the deceased alive on 1-16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Fleet Luckett MD						22c. DATE SIGNED 1-17-69						
22d. PHYSICIAN'S NAME (Type) W. Fleet Luckett						22e. ADDRESS 5000 PENNO Rd N W						
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE 1-29-1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION (City or Town) (County) Co. (State) Md. Colmar Manor Prince Georges		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,						ADDRESS 5150 Wisc. Ave.		25a. BUREAU STR. NO JAN 24 1969		25b. REGISTRAR'S SIGNATURE Charles J. Judge		
N.W. Wash., D.C., 20016						DATE JAN 24 1969						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-14
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR			
First Middle Last Russell Eugene Stup			Jan. Month 17 Day 69 Year			1:40am			
3. SEX Male		4 RACE White		5. DATE OF BIRTH 4-19-13		6. AGE (In years lost birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Petroleum Co		
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Montgomery		13c CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5313 Willard Ave.	
14 FATHER'S NAME First Middle Last Elmer Elmer Stup Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Nora Nora Schwartz						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b SOCIAL SECURITY NO (If not give war or dates of service) WW II 578-10-9364		17 INFORMANT Hospital Records		Address Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebexia</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Small bowel obstruction, partial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of colon & extension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>4 yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bronchopneumonia, hypostatic</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>69</u> , to <u>1/17</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1/16</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>do</u>) view the body after death.									
22b. SIGNATURE <u>Dr. Charles Ligon</u>		22c. DATE SIGNED <u>1/17/69</u>		22d. PHYSICIAN'S NAME (Type) Dr. Charles Ligon		22e. ADDRESS <u>Sandy Spring, Md 2086</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1-20-69		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR JAN 23 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

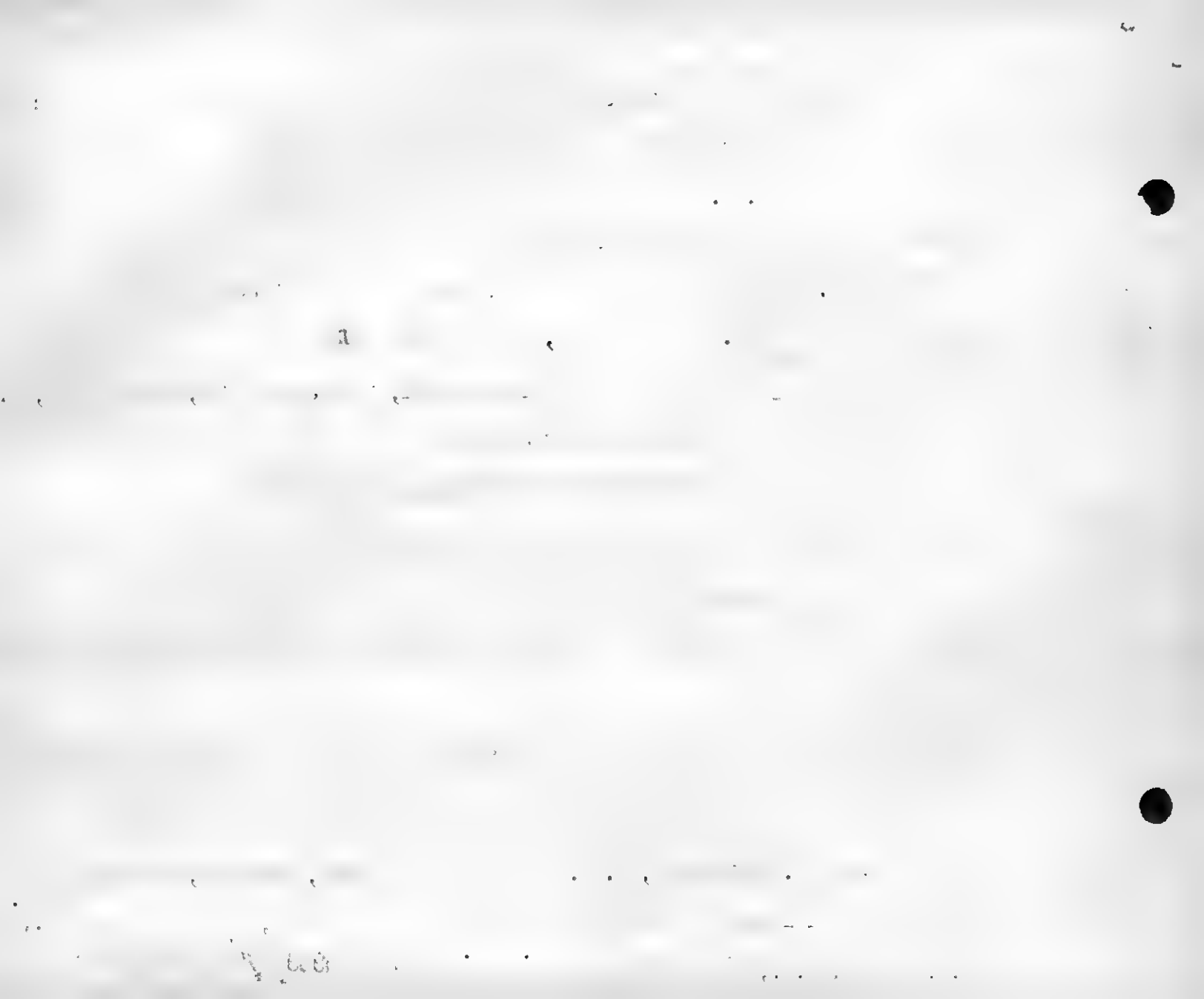
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) JOHN SWECKER		First SWECKER		Middle GLEN		Last JOHN SWECKER		2a. DATE OF DEATH Month 1 Day 12 Year 69		2b. HOUR 9:20 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-25-08		6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Laborer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 North Adams Street			
14. FATHER'S NAME First ELMER Middle C. Last Swecker		15. MOTHER'S MAIDEN NAME First Clementine Middle Bible Last 									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 		17. INFORMANT Address Olney, Md Admission Rec'd., Montgomery General Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) SEPTIC SHOCK											
DUE TO, OR AS A CONSEQUENCE OF (b) NECROTIZING PAPILLITIS											
DUE TO, OR AS A CONSEQUENCE OF (c) PYELONEPHRITIS - ACUTE + CHR											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES - SEVERE - MYOCARDIAL INFARCTION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State 							
22a. I certify that (I) (this hospital) attended the deceased from OCT 1963 to 12 JAN 1969 , that (I) (we) last saw the deceased alive on 12 JAN 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald R. Lewis		22c. DATE SIGNED 13 JAN 69		22d. PHYSICIAN'S NAME (Type) Donald R. Lewis, M. D.							
22e. ADDRESS 700 CLOVERLY SILVER SPR. Md											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1-16-69		23c. NAME OF CEMETERY OR CREMATORY True Gospel		23d. LOCATION (City or Town) (County) (State) Lisbon Howard Md.					
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonville, Md.		25a. REC'D. BY REGISTRAR 10 1969		25b. REGISTRAR'S SIGNATURE 			
DATE											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First Helen	Middle Sipple	Last TAFT	2a. DATE OF DEATH Month JAN Day 4 Year 69		2b. HOUR 10:20	
3 SEX FEMALE		4 RACE CAUCASION		5. DATE OF BIRTH 13 MAR 1904		6 AGE (In years and months) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last 12 months, if any, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE VA.		13b. COUNTY FALLS CHURCH		13c. CITY OR TOWN FALLS CHURCH		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3447 JOAN COURT
14. FATHER'S NAME WALTER		First	Middle S.	Last SIPPLE	15. MOTHER'S MAIDEN NAME CAROLINE ADAMSBAUGH		First	Middle ADAMSBAUGH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 220 09 6773		17 INFORMANT THOMAS TAFT, 3447 JOAN COURT, FALLS CHURCH, VA				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTI PULMONARY EMBOLI 1560 DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF GALL BLADDER WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2 JAN , 19 69 , to 4 JAN , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 JAN , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John A. Routenberg</i>		DEGREE JOHN A. ROUTENBERG, M. D.		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 JAN 68		
22d. PHYSICIAN'S NAME (Type) JOHN A. ROUTENBERG, M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1-6-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Md. Suitland, Prince Georges Co.,		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave.				25a. REC'D BY REG. STRAR DATE N 8 1969		25b. REG. STRAR'S SIGNATURE <i>John A. Routenberg</i>		
N.W., Wash., D.C., 20016								



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Thomas Eugene Taylor						Month Day Year		Jan 7 1969	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
M.	W.	SEP. 10. 1966	2 YRS	MONTHS	DAYS	Month Day Year		Jan 7 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Maryland.		U.S.A.				Montgomery.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda.			Suburban.			Child			
13a USUA. RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY, IN IS?	
Maryland.			Montgomery			Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			9926 Fleming Ave			
Thomas E Taylor			Josephine A. Certain						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
---			---			Thomas E. Taylor-father-same item #13a			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Interstitial Viral.									
4XOX DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			HOUR A.M. P.M.		19				
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
John G. Ball			M.D.			Jan. 8. 1969.			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						
John G. Ball			7936 Old Geo. Rd. Bethesda, Md.						
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		1/10/69		Gate of Heaven		Silver Spring, Maryland			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home				1331 Rock Pike Rockville, Maryland		DATE JAN 14 1969		Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST. DEATH		2b HOUR	
Horace		M.		Thompson				Jan 29 1969		6 A M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	
M	W.	17-6-1892		76 YRS						Jan 29 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Clarksburg				Route 355				Farmer			
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIM TS?		13e STREET AND NUMBER			
Maryland		Montgomery		Clarksburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 355			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last Douglas Thompson				First Middle Last Ella Bennett							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16b SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT		ADDRESS	
No				579-44-3782				Ellis Roberson,		Dickerson, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. 6:30 AM Jan 29 1969				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Left car running in garage attached to house</u>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>				21f LOCATION Street or R.F.D. No City or Town County State <u>Route 355 Clarksburg Montgomery Md</u>			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b DATE SIGNED <u>Jan 29 1969</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)							
22c NAME OF CEMETERY OR CREMATORY <u>Hyattstown</u>				22d LOCATION (City or Town) (County) (State) <u>Hyattstown, Md.</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE <u>Feb. 1, 1969</u>				23c NAME OF CEMETERY OR CREMATORY <u>Hyattstown</u>			
24 FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>				25a REC'D BY REG STRAR DATE <u>FEB 3 1969</u>				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01256

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-3-69
Examined by Medical Examiner
155

1. DECEASED NAME (Type or print) First SAMUEL Middle JASPER Last THOMPSON			2a. DATE OF DEATH Month 1 / Day 1 / Year 69		2b. HOUR 8:22 P.M.
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 7/25/01		6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MONTGOMERY GENERAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Roads Commissioner Govt		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SANDY SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1811 EDNOR ROAD Box 11	
14. FATHER'S NAME First Middle Last JAMES -- THOMPSON		15. MOTHER'S MAIDEN NAME First Middle Last ARMINTA -- RAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO 154-12-9549		17. INFORMANT <i>Mrs. D. Harriott</i> Medical Records Address <i>Spr. Md. 1811 Ednor Rd. Sandy</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussion of prostate & metastasis</i> <i>195X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/31</i> , 19 <i>68</i> , to <i>1/1</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>12/31</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A.D. Bonifant M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-2-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>A.D. BONIFANT</i>		22e. ADDRESS <i>Sandy Springs, Md.</i>			
23a. BURIAL CREMATION <i>Removal</i>		23b. DATE <i>1-6-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>	
23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>					
24. FUNERAL DIRECTOR <i>E. Lee</i>		ADDRESS <i>Spr. Md. 8434 Georgia Ave</i>		25a. REC'D BY REGISTRAR <i>1969</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <u>MINNIE BELL THRIFT</u>						2a DATE OF DEATH <u>1</u> Month <u>18</u> Day <u>69</u> Year		2b HOUR <u>6:30</u> M			
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>9-18-79</u>		6 AGE (In years last birthday) <u>89</u> YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <u>VA.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY CO.</u> Md					
10 CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wash. State Hosp</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>D.C.</u> COUNTY <u>-</u>			13c CITY OR TOWN <u>Wash. D.C.</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>110 Gallatin ST NW</u>				
14 FATHER'S NAME First <u>JOSEPH</u> Middle <u>-</u> Last <u>REYNOLDS</u>				15 MOTHER'S MAIDEN NAME First <u>ANNIE</u> Middle <u>-</u> Last <u>M'GUIRE</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <u>579-62 6639</u>		17 INFORMANT <u>Curtis Thrift (son)</u> Address <u>110 Gallatin ST NW</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 21, 1969</u> to <u>Jan 23, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 21, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>[Signature]</u> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>Jan 23, 1969</u>					
22d PHYSICIAN'S NAME (Type) <u>W. B. [Signature]</u>				22e ADDRESS <u>[Address]</u>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <u>JAN 21, 1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>GIBBEN BAPTIST CHURCH</u>		23d LOCATION (City or Town) <u>VILLAGE VA.</u> (County) (State)					
24 FUNERAL DIRECTOR <u>WARNER E. THOMPSON INC</u> ADDRESS <u>8434 GEORGETOWN RD SPOON SPRING MD</u>				25a REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JAN 23 1969</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

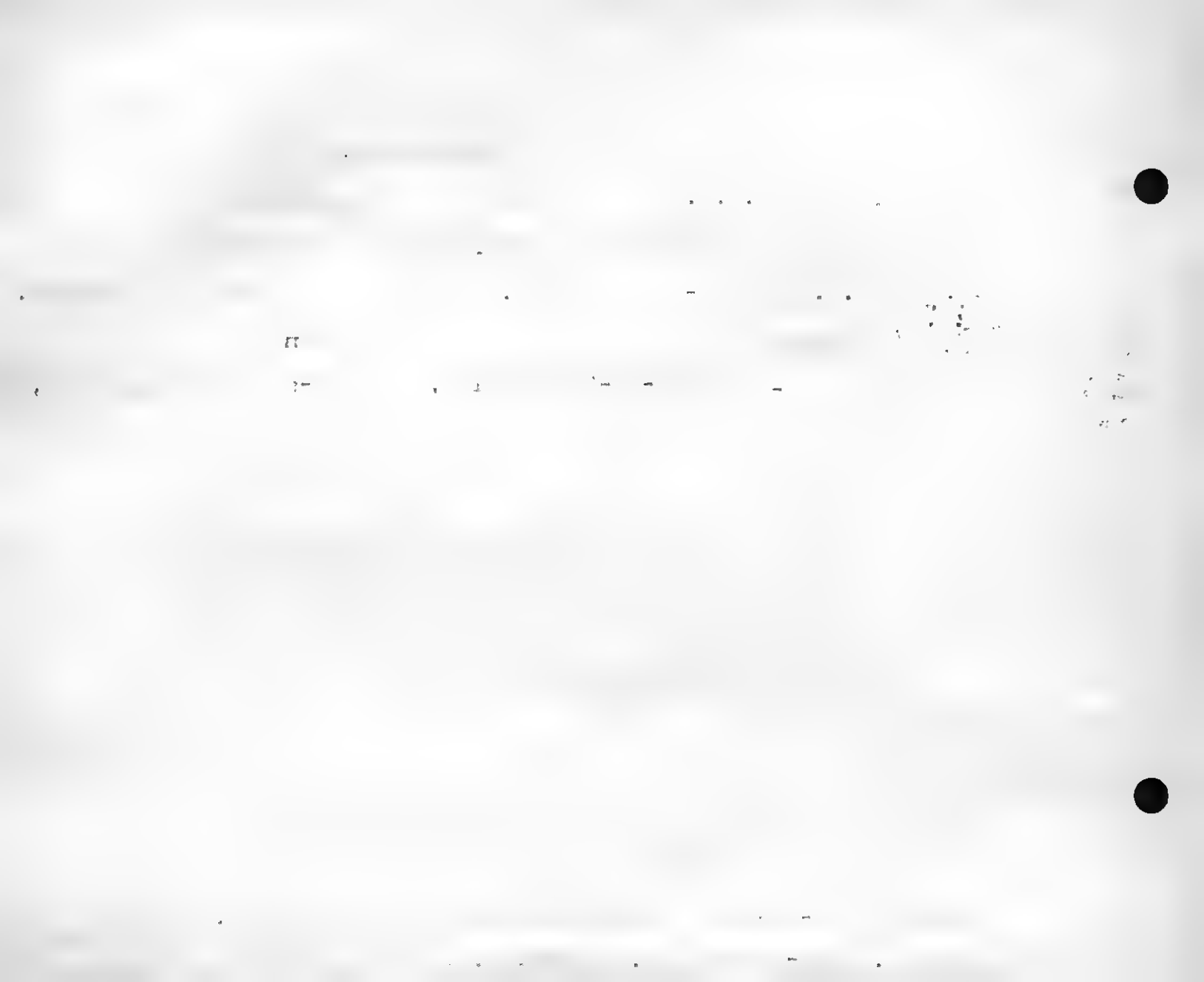
VR A15 141
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Rudolph</i> First <i>Todd</i> Middle Last						2a. DATE OF DEATH <i>Jan 19 1969</i> Month Day Year			2b. HOUR <i>6:30</i> MIN		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>8/5/14</i>		6 AGE (In years last birthday) <i>54</i> YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>New York</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>New York</i>				13b COUNTY <i>New York</i>		13c CITY OR TOWN <i>Newburgh</i>		13d INSIDE CITY - MILES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
14. FATHER'S NAME First <i>Rupert</i> Middle Last <i>Todd</i>				15 MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Fluss</i> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <i>Army</i>		17 INFORMANT <i>Dr. 2</i> Address <i>Seclusion</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Infection of Brain Stem</i>										<i>4 hrs.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Basilar Artery Thrombosis</i>										<i>6 hrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arterio Sclerosis</i>										<i>Yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19 <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 16, 1969</i> to <i>Jan 19, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 18, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>John M. Smith, MD</i> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>1/19/69</i>			
22d PHYSICIAN'S NAME (Type)						22e ADDRESS <i>Barnesville, Md. Mont. Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>1/22/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d LOCATION (City or Town) <i>New Windsor, N.Y.</i> (County) (State)					
24 FUNERAL DIRECTOR <i>W.C. Hiltner, Barnesville, Md.</i> ADDRESS						25 JAN 23 1969		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			
						DATE					

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <i>Nellie</i>			Middle <i>B.</i>			Last <i>Treynor</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>13</i> Year <i>1969</i>			2b. HOUR <i>10:45</i> AM		
3. SEX <i>F</i>			4. RACE <i>W</i>			5. DATE OF BIRTH <i>June 17, 1889</i>			6. AGE (In years last birthday) <i>79</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Conn.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>			Md					
10. CITY OR TOWN OF DEATH <i>Kensington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Hall Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>D.C.</i>			13b. COUNTY <i>-</i>			13c. CITY OR TOWN <i>Wash.</i>			3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>621 Constitution Ave.</i>			NE		
14. FATHER'S NAME First <i>Unknown</i>			Middle <i>Unknown</i>			Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First <i>Unknown</i>			Middle <i>Unknown</i>			Last <i>Unknown</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO <i>579-52-3911</i>			17. INFORMANT <i>Paul E. Treynor-son</i>			Address <i>New Carrollton, Md</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>												<i>Days</i>					
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
(b) <i>Arteriosclerosis</i>												<i>Years</i>					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>																	
19a. DATE OF OPERATION <i>No</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (the hospital) attended the deceased from <i>1/9, 1969</i> , to <i>present</i> , that (I) (we) last saw the deceased alive on <i>1/13, 1969</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>John B. Umhau</i>						DEGREE <i>MD</i>			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>1/13/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU</i>						22e. ADDRESS <i>8805 Conn. Ave. May Chesa</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>1-16-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>								
24. FUNERAL DIRECTOR <i>Lee Fun. Home-300 4th St. NE Wash., D.C.</i>						ADDRESS			25a. RECD BY REGISTRAR <i>JAN 20 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01260

1. DECEASED NAME (Type or print) <i>First</i> <u>Layne B.</u> <i>Middle</i> <u>Tritabaugh</u> <i>Last</i>			2a. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1969</u> 2b. HOUR <u>8:05 PM</u>	
3. SEX <u>female</u>	4. RACE <u>white</u>	5. DATE OF BIRTH <u>6-27-18</u>		6. AGE (In years last birthday) <u>54</u> YRS
7a. BIRTHPLACE (State or foreign country) <u>oklahoma U.S.A</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Beaumont</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Home</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Home maker</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u> 13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Rockville</u>	13d. HOUSE CITY OR TOWN? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>4613 Olden Rd.</u>	
14. FATHER'S NAME <i>First</i> <u>Unknown</u> <i>Middle</i> <u></u> <i>Last</i>		15. MOTHER'S MAIDEN NAME <i>First</i> <u>Unknown</u> <i>Middle</i> <u></u> <i>Last</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give service branch and dates)		16b. SOCIAL SECURITY NO. <u>59-20-6433</u>	17. INFORMANT <u>Kenneth Tritabaugh</u> Address <u>5200</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>hepatic coma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Liver cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>undetermined</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary heart disease</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15/1969</u> to <u>1/16/1969</u> , that (I) (we) last saw the deceased alive on <u>1/16/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (did not) view the body after death.				
22b. SIGNATURE <u>Faruk Ozer</u>	DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>1/16/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>FARUK OZER</u>	22e. ADDRESS <u>1125 Rockville Pike Rockville, MARYLAND</u>			
23a. BURIAL, CREMATION, REINTERMENT (Type) <u>Cremation</u>	23b. DATE <u>1/20/1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		1331 Rockville Pike Rockville, Md		25a. REC'D BY REGISTRAR <u>JAN 21 1969</u>
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01261		01261							
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
Russell						Trupo		Month 5 Day 6 Year 69	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS HOURS
M	Caucasian		6/23/15		53 YRS.				15 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. Va.		U. S. A.				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		USIA		U. S. Govern.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Nheaton				11920 Valleywood Dr.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Leonard		Trupo						Minnie Mike	
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes		WORLD WAR II		232-01-5862		Mrs. Agnes M. Trupo		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Hypertension with metastases</u>									Year.
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1969, to Jan 5, 1969, that (I) (we) last saw the deceased alive on Jan 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
						Jan 5, 1969			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
BLAINE H EIG		301 Georgia Ave Silver Spring, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Jan. 8, 1969		Gate of Heaven		Silver Spring		Md.	
24. FUNERAL DIRECTOR		500 University Blvd W Silver Spring, Md		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Thomas Hallin				DATE JAN 9 1969					

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>First Middle Last</i> <i>Spiros Andrew Tzaferis</i>			2a DATE OF DEATH Month Day Year <i>JAN. 12 1969</i>			2b HOUR <i>7:30 A.M.</i>			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>MARCH 15 1886</i>		6 AGE (In years last birthday) <i>82 YRS.</i>		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Greece</i>		7b CITIZEN OF WHAT COUNTRY? <i>CANADA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md			
10 CITY OR TOWN OF DEATH <i>Kensington</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens Sanit</i>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>RESTAURANT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>owner</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>		13b COUNTY <i>MONTGOMERY</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>8401 Cedar St Silver Spring</i>	
14 FATHER'S NAME <i>First Middle Last</i> <i>Andrew -- Tzaferis</i>			15 MOTHER'S MAIDEN NAME <i>First Middle Last</i> <i>Kiriakos -- Pothakas</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) <i>--</i>			
16b SOCIAL SECURITY NO. <i>215-38-2945</i>			17. INFORMANT <i>Grace Tzaferis 8401 Cedar Street, Silver Spring, Md</i>						
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Left ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary atherosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last <i>10 days</i> <i>10 days</i> <i>10 years</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1969</i> , to <i>January 12 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan. 12 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE <i>Samuel T. Kibbe</i>		22c DEGREE <i>MD</i>		22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e DATE SIGNED <i>1-12-69</i>			
22d PHYSICIAN'S NAME (Type) <i>Samuel T. Kibbe, M.D.</i>		22e ADDRESS <i>4801 Georgia Ave, Silver Spring, Md.</i>							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE <i>1-14-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery Prince Georges, Maryland</i>		23d LOCATION (City or Town) (County) (State)		23e REC'D BY REGISTRAR	
24 FUNERAL DIRECTOR <i>Mr. E. N. Phrey</i>		24b ADDRESS <i>11311 Georgia Avenue</i>		24c DATE <i>JAN 16 1969</i>		24d REASON FOR SIGNATURE <i>Funeral Director</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)
30M REV. 1-58

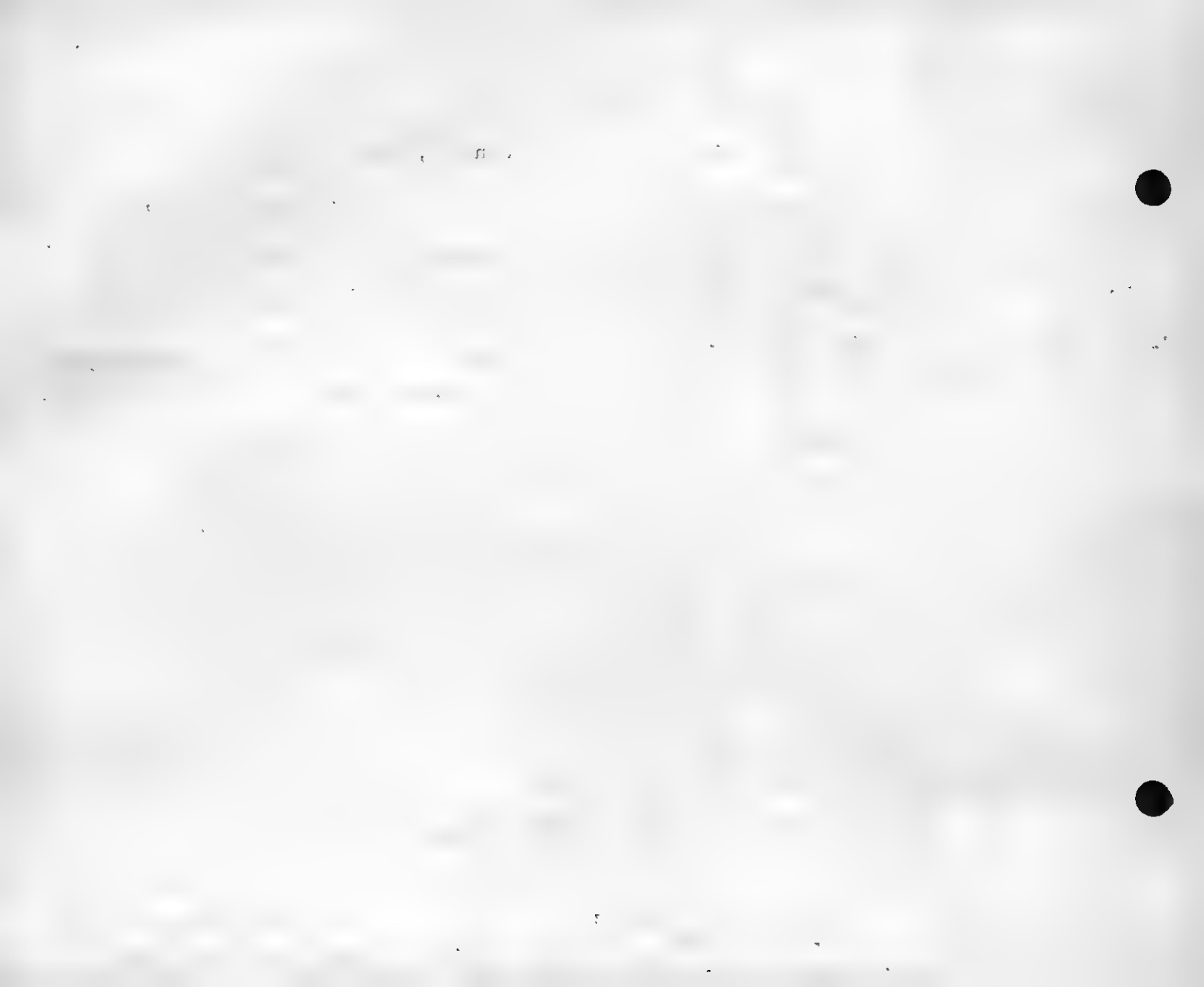
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01267

01263

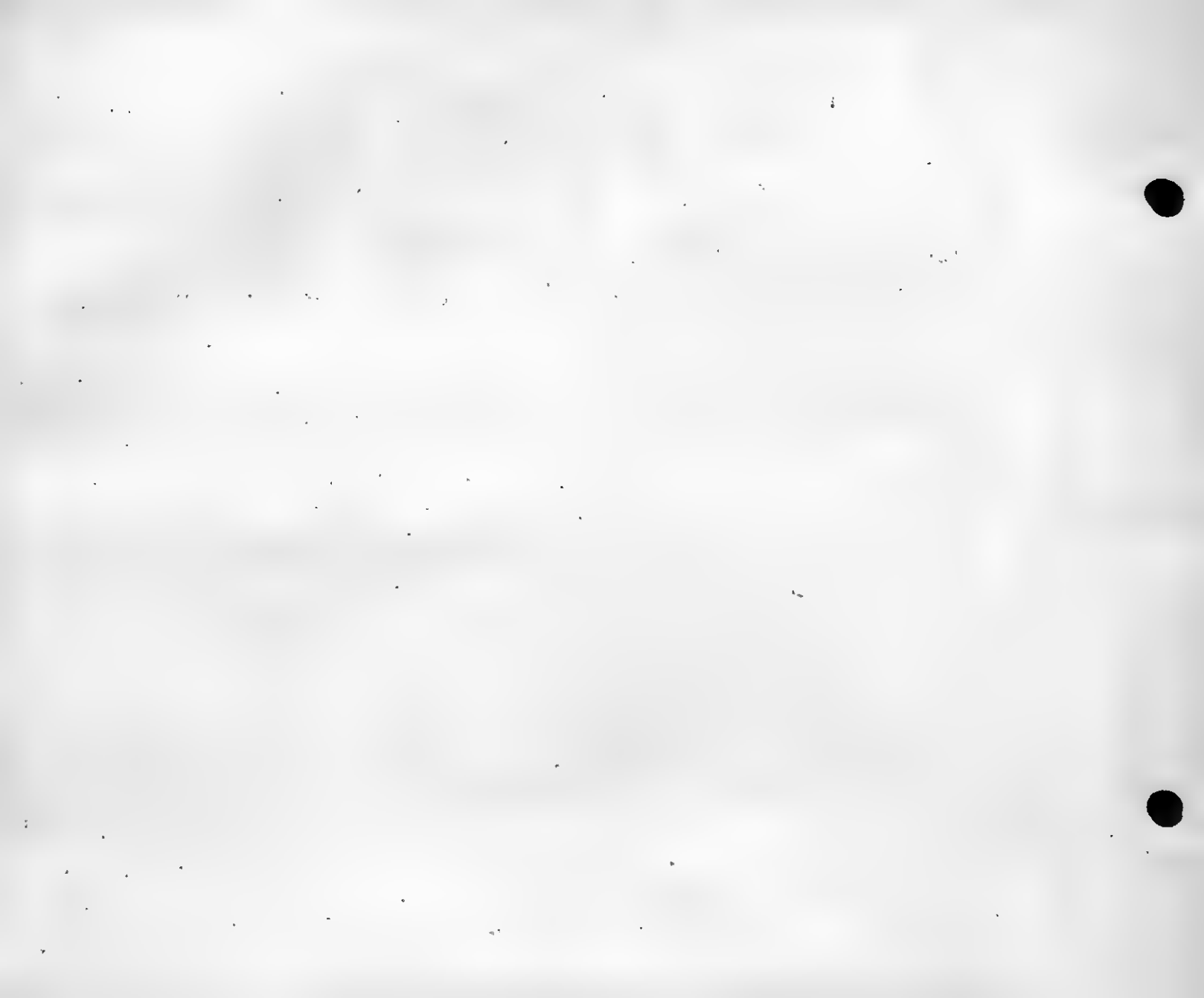
1. DECEASED NAME (Type or print) MATTIE		First Bertha HANSEN		Last VEREIDE		2a. DATE OF DEATH Month January Day 30 Year 1969			2b. HOUR 9:30 PM		
3 SEX female		4 RACE White		5. DATE OF BIRTH June 24, 1886		6 AGE (In years lost birthday) 82 YRS.		7 UNDER 1 YEAR MONTHS 0 DAYS 0		8 UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County, Md.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3360 Chiswick Court			
14. FATHER'S NAME First N. Middle L. Last Hansen		15. MOTHER'S MAIDEN NAME First (Unknown) Middle Last 									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. yes		17 INFORMANT Milton B. Vereide Address 1216 Perkins Avenue, N. W. Canton, Ohio					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4350 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (b) 3 days (c) years DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension and Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Sept 27, 1967 to Jan 30, 1969 , that (I) (we) last saw the deceased alive on Jan 30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard A. Yates		22c. DATE SIGNED 1/30/69		22d. PHYSICIAN'S NAME (Type) Richard A. YATES							
22e. ADDRESS OLNEY, Md.											
23a. BURIAL, CREMATION, FURNAL (Specify)		23b. DATE 2-1-1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Md.					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR 5		25b. REGISTRAR'S SIGNATURE Charles Jones							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First <i>Pearl</i>			Middle <i>(none)</i>			Last <i>Volensky</i>			2a. DATE OF DEATH Month <i>January</i> Day <i>23</i> Year <i>1969</i>			2b. HOUR <i>3:30</i> AM		
3 SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>August 9, 1889</i>			6 AGE (In years) last birthday <i>68</i> YRS.			IF UNDER YEAR MONTHS <i>68</i>		IF UNDER 24 HRS. HOURS <i>3:30</i> MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>America</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery County</i> Md								
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Hosp. + Sanitarium</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>			13d. INSIDE CITY LAW? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>1220 Blair Mill Rd - Apt. #115</i>					
14. FATHER'S NAME First <i>?</i> Middle <i>Hartman</i> Last <i>Hartman</i>			15. MOTHER'S MARDEN NAME First <i>?</i> Middle <i>?</i> Last <i>?</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>217-30-1011</i>			17. INFORMANT <i>Leona Perkins - 9039 Sligo Cr. Pkwy. - S.S., Md</i>			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i>												<i>2 days</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>Congestive Heart Failure</i>												<i>2 years</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Cardiovascular Disease</i>												<i>8 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus, Emphysema</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>JULY 1960</i> , to <i>JAN 23, 1969</i> , that (I) (we) last saw the deceased alive on <i>JAN 22, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Robert L. Krichmar</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>JAN. 23 1969</i>								
22d. PHYSICIAN'S NAME (Type) <i>ROBERT L. KRICHMAR M.D.</i>			22e. ADDRESS <i>7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20022</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>1-26-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>DNAI ISRAEL CEM.</i>			23d. LOCATION (City or Town) <i>PITTSBURGH</i>			(County) <i>PA.</i>					
24. FUNERAL DIRECTOR <i>Goodall Funeral Home</i>			ADDRESS <i>4217 9TH ST. N.W.</i>			25a. REC'D BY REGISTRAR <i>JAN 28 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01269											
01265											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) ARMSTEAD First LEE Middle WALKER Last			2a. DATE OF DEATH Month 1 Day 24 Year 69			2b. HOUR 6 A.M.					
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 3/25/01		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Delmar, Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery County Md		
10. CITY OR TOWN OF DEATH Wheaton, Md.			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) W.N.M. 901 Arbor Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hotel Worker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE 1221 1st NW D.C.			13b. COUNTY DC.			13c. CITY OR TOWN WASH			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Andrew Jackson Walker First Andrew Middle Jackson Last Walker			15. MOTHER'S MAIDEN NAME Yetta Brown First Yetta Middle Brown Last Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 577-05-4301A			17. INFORMANT Mrs. Edna B. Walker 1221 "M" St., N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ENCEPHALOMALACIA											
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL THROMBOSIS											
DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 11			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 31 , 19 67 , to 1/24 , 19 69 , that (I) (we) last saw the deceased alive on 1/24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lawrence R. Cannaday, M.D.						22c. DATE SIGNED 1/24/69					
22d. PHYSICIAN'S NAME (Type) LAWRENCE R. CANNADAY						22e. ADDRESS 3632-GEORGIA AVE. N.W.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1/27/69			23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Robert McLean 1821-9-8th St			25a. REC'D BY REGISTRAR JAN 28 1969			25b. REGISTRAR'S SIGNATURE James J. ...					

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital DOA		2. USUAL RESIDENCE (If deceased lived, If institution: Residence before admission) a. S Virginia <input checked="" type="checkbox"/> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 2400 S. Inge Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ernest P. Walker		4. DATE OF DEATH Month Day Year Jan. 31, 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/2/91
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't director of National Zoo	11. BIRTHPLACE (County & State, or foreign country) Blue Springs, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elza J. Walker	
14. MOTHER'S MAIDEN NAME Avis Pillsbury		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO		17. INFORMANT Address Winifred W. Leering same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4109 MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC HEART DISEASE (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 10 YRS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV. 1956 to JAN. 31, 1969 , that (I) (was) last saw the deceased alive on JAN. 28, 1969 , and that death occurred at 1020 AM , from the causes and on the date stated above.			
22a. SIGNATURE Bertel Nelson M.D.		22b. DATE SIGNED JAN 31, 1969	
22c. PHYSICIAN'S NAME (Type) BERTEL NELSON		22d. ADDRESS 916 19th St. N.W. WASHINGTON, D.C. 20006	
23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical Board 2/1/69		23b. DATE THEREOF 2/1/69	
23c. NAME OF CEMETERY OR CREMATORY George Washington University School Wash. L.C.		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company 2901 14th St. N.W. Washington, L.C.		25. REG'D BY REGISTRAR of Medicine DATE FEB 4 1969	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE	

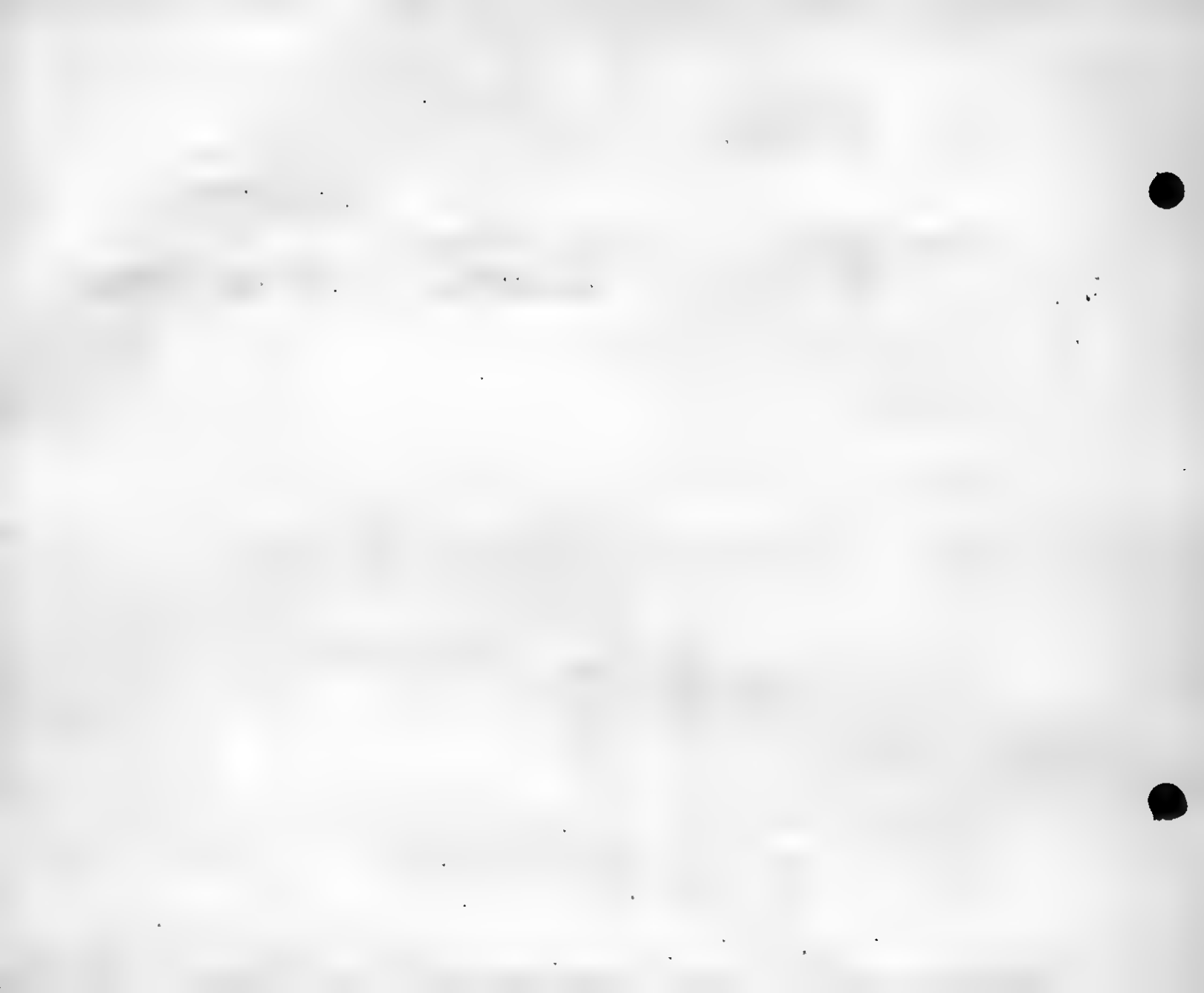
FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <i>Wildert N. Wallace</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>1</i> - Day <i>9</i> - Year <i>69</i>			2b. HOUR <i>4:30</i> AM		
3. SEX <i>Male</i>	4. RACE <i>NEGRO</i>	5. DATE OF BIRTH <i>4/20/37</i>	6. AGE (in years) Last birthday <i>31</i> YRS	7. UNDER 24 HRS MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>1</i> - Day <i>9</i> - Year <i>69</i>		
7a. BIRTHPLACE (State or foreign country) <i>S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in home, give street address) <i>Holy Cross Hosp.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. U.S. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>PA</i>		13b. COUNTY <i>Philadelphia</i>		13c. INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>435 High Street</i>		
14. FATHER'S NAME First <i>Milledge</i> Middle <i>-</i> Last <i>McCossell</i>			15. MOTHER'S M.A.DEN NAME First <i>Lucile</i> Middle <i>Wallace</i> Last <i>S.C.</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		
16b. SOCIAL SECURITY NO			17. INFORMANT <i>Cleveland Wallace</i>			18. ADDRESS <i>1609 Madison St Baltimore</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonitis and Sickle-cell anemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>crisis precipitated by overdose of</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>several drugs, suicidal.</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year Hour A.M. <i>1-1</i> P.M. <i>1969</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Deceased, depressed, took overdose of drugs.</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Motel</i>			21f. LOCATION Street or R.F.D. No <i>Wheaton Montg. Md.</i>		
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Belden R. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>JAN. 9, 1969</i>		
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, town, or county) <i>Wheaton</i>		
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>1-17-69</i>		23b. DATE <i>1-17-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Family Plot</i>		23d. LOCATION (City or town) (County) (State) <i>Remmox, S.C.</i>		
24. FUNERAL DIRECTOR <i>Latimer Funeral Home</i>				ADDRESS <i>3831 Ga. Ave. Wash. D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 16 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print) <i>Henry Frank Walls</i>			Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <i>Jan 30 1969</i>		2b. HOUR OF DEATH <i>8:30 M</i>		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>May 1, 1886</i>	6 AGE (In years last birthday) <i>83 1/2</i> YRS	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <i>Jan 30 1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		2d. HOUR OF DEATH <i>8:30 M</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>814 Richmond Ave</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Machinist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Navy Dept.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY, APTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>814 Richmond Avenue</i>	
14. FATHER'S NAME First <i>Henry</i> Middle <i>Clay</i> Last <i>Walls</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Jolson</i> Last <i>Walls</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>Yes</i>		17. INFORMANT ADDRESS <i>Daisy A. Walls 814 Richmond Ave. S.S., Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4123 Acute Coronary Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Belden K. Heap</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>JAN. 30, 1969</i>		
EXAMINER'S NAME (Type) <i>BELDEN K. HEAP M.D.</i>		ADDRESS (Street, P.O. Box, or County) <i>Warner E. Humphrey, Inc. 8434 Ga. Avenue Md.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-3-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>				
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>		ADDRESS <i>8434 Ga. Avenue Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) HELEN K. WARE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 7 Year 1969			2b. HOUR 5:43 PM			
3 SEX Female	4 RACE Cauc	5 DATE OF BIRTH JUNE 4, 1999	6 AGE (In years and birthday) 69 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month — Day 7 Year 1969			
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 135 Sligo Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY Montgom		13c. CITY OR TOWN SL. SPR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 735 Sligo Avenue	
14. FATHER'S NAME First Patrick Middle - Last Kelly			15. MOTHER'S MAIDEN NAME First Catherine Middle - Last Owens			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b. SOCIAL SECURITY NO 577-01-0372			17. INFORMANT Mrs. Mary C. Matorin			ADDRESS 11916 College Ave. Wheaton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 1-10-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Ce.		23d. LOCATION (City or Town) (County) (State) Arlington Virginia		22b. DATE SIGNED JAN. 7, 1969	
24. FUNERAL DIRECTOR M. Andre Dwyer		ADDRESS 1100 E. North Ave. S.S. Md.		25a. REC'D BY REG. STRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE Richard J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Betty			First Middle Last			2a. DATE OF DEATH Month 5 Day 5 Year 1969			2b. HOUR 8:03 A.M.		
3. SEX Female			4. RACE CAUCASIAN			5. DATE OF BIRTH 7-5-26			6. AGE (in years last birthday) 42 YRS.		
7a. BIRTHPLACE (State or foreign country) Missouri			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased had abode) STATE MARYLAND			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e. STREET AND NUMBER 13125 BEAVER TERRACE			14. FATHER'S NAME First William Middle Adams Last			15. MOTHER'S MAIDEN NAME First Lillian Middle (Unknown) Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Husband Myron R. Way			Address Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYELOMONOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Few Hours CIRCA 2 MONTHS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1968 to 1/5, 1969 , that (I) (we) last saw the deceased alive on 1/5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lawrence D. Marcus, M.D.						22c. DATE SIGNED 1/5/69					
22d. PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS						22e. ADDRESS 2446 Reedie Drive Wheaton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 1-6-69			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City or Town) (County) (State) Suittland, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR JAN 9 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01271

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOURS
John E Wease					Jan 27			1969	4:20 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c DATE PRONOUNCED DEAD	Month	Day	Year	2d HOUR
Male	White	9-7-20	48 YRS		Jan 27			1969	4:20 PM
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md			
Virginia	USA			Montgomery					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Bethesda	Suburban		Retired		6 between				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER					
Md	Mont	Rockville		RT #1 Box 148					
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
John W Wease				Nellie				Rodgers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT		ADDRESS				
No		231-03-0446	Edith Wease Wease		Same as above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Insufficiency									Months
5710 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									month-
(b) Jaundice Cirrhosis of the Liver									
DUE TO, OR AS A CONSEQUENCE OF									year
(c) Chronic Alcoholism									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
1 Coronary Thrombosis - 2 Hemmo-Peritoneum-Secondary to Paracentesis.									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		11 PM 1/27 1969		Routine Paracentesis					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCAT ON Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball		M.D.		22b. DATE SIGNED		Jan 28, 1969	
EXAMINER'S NAME (Type)		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCAT ON (City or Town) (County) (State)			
Burial		1/30/69		Parklawn Cemetery		Rockville, Montg. Maryland			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Tyspn Wheeler Funeral Home 1331 Rockville Pike Rockville, Maryland		JAN 30 1969		Charles Judge					

CERTIFICATE OF DEATH

01272

1 DECEASED-NAME (Type or print) G First Raymond Middle Webb Last		2a DATE OF DEATH Month Jan Day 23 Year 1969		2b HOUR 12:15 M
3 SEX male	4 RACE white	5 DATE OF BIRTH 1/24/92	6 AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital	12a USJA: OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4901 MONTGOMERY LANE
14 FATHER'S NAME First William Middle L Last Webb	15 MOTHER'S MAIDEN NAME First Isabelle Middle Mac Last Shuff	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give branch or dates of service) Yes W.W. I		
16b SOCIAL SECURITY NO 215-44-7910	17 INFORMANT Mrs. Norine G. Webb, Bethesda, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis of abdomen DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of urinary bladder DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 5 mos
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION 11/19/68	19b CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of bladder	20a AUTOPSY? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. 19 Month Jan Day 22 Year 1969 P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No 5415 W. Cedar Lane City or Town Bethesda County Montgomery State Md.		
22a I certify that (I) (this hospital) attended the deceased from 1944 to Jan 23, 1969 , that (I) (we) last saw the deceased alive on Jan 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b SIGNATURE Stewart Clapp M.D.	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED Jan 23 '69	
22d PHYSICIAN'S NAME (Type) STEWART CLAPP MD	22e ADDRESS 5415 W. Cedar Lane Bethesda Md.			
23a BURIAL, CREMATION, & REMOVAL (Specify) Burial	23b DATE 1-25-69	23c NAME OF CEMETERY OR CREMATORY Acacia Pk. & Rest Haven	23d LOCATION (City or Town) Buffalo, (County) New York (State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.	25a RECEIVED BY REGISTRAR JAN 28 1969	25b REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular report, page 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JOSEPH		W.		WELLS				1 Month 20 Day 69 Year		828 M	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS		IF UNDER 24 HRS HOURS M N	
m		W		12-16-1881		86 87 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U S A				MONTGOMERY Co.				Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
KENSINGTON		KENSINGTON GARDENS SAN.		PAINTER		auto shop					
13a USUAL RESIDENCE (Where deceased lived, if institution, give date before admission) STATE		13b COUNTY		13c CITY OR TOWN		3a IS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER			
MARYLAND		MONTGOMERY		SILVER SPRING		YES		717 UNIVERSITY BLVD. Apt. 1		East	
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Everett		(Unknown) W.		Wells				Mary		(Unknown) A. Kelly	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, and dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		PHONE		Address			
No		578-03-6192		MRS. JOSEPHINE WILLIAMS		593-0697		10013 ROGART		SSP MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>										8 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of prostate gland</u>										11 months	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>with metastasis</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic urinary tract infection - penicillin</u>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A M Month Day Year P M 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 17, 1968 to Jan 20, 1969, that (I) (we) last saw the deceased alive on Dec 30, 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death											
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
Philip E. Jones M.D.		1-20-69		Philip E. Jones M.D.		800 Pershing Drive Silver Spring Md.					
23a BURIAL, CREMATION, REMOVA. (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		1-23-1969		Blandford Cemetery		Petersburg, Virginia					
24a FUNERAL DIRECTOR		24b ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
C. Glen Carter		Sil. Spr., Md.		JAN 24 1969		[Signature]					
Warner E. Pumphrey, Inc. 8434 Georgia Avenue											

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>George Thomas Welsh</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>1969</i>			2b. HOUR <i>12-00 AM</i>		
3 SEX <i>M</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>10-12-34</i>	6 AGE (in years last birthday) <i>YRS</i>	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>2</i> Year <i>1969</i>			2d. HOUR <i>M</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>none</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Steel Business</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>STATE 7 and</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>510 Silver Spring Ave.</i>		
14. FATHER'S NAME First <i>Claude</i> Middle <i>--</i> Last <i>Welsh</i>				15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>--</i> Last <i>Kane</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16b. SOCIAL SECURITY NO <i>218-30-6188</i>				17 INFORMANT <i>Barbara E. Welsh</i>				ADDRESS <i>Sil. Spr., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple skull fractures with</i>											
880x DUE TO, OR AS A CONSEQUENCE OF (b) <i>massive intracranial hemorrhage</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>incurred in fall.</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>11 30 P.M. 1-1 19 69</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Deceased fell down cellar steps at home.</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No <i>Silver Spring</i>		City or Town <i>Montgomery</i>		County <i>Md.</i>		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Reap</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>JAN. 2, 1969</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		ADDRESS (Street, P.O. box, town, county) <i>Silver Spring, Md.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-6-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Maryland</i>	
24. FUNERAL DIRECTOR <i>J.W. Lee</i>				ADDRESS <i>Sil. Spr., Md.</i>				25a. REC'D BY REGISTRAR <i>JAN 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
Warner E. Pumphrey, Inc. 8431 Georgia Avenue											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>McLean</i> First <i>FORMAN</i> Middle <i>Whitcomb</i> Last			2a. DATE OF DEATH Month <i>Jan</i> Day <i>23</i> Year <i>1969</i>			2b. HOUR <i>2:55</i> PM	
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>4/3/07</i>		6 AGE (in years last birthday) <i>61</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Self-employed</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSUR CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>5305 McKinley St.</i>		14 FATHER'S NAME First <i>FREDERICK</i> Middle <i>-</i> Last <i>WHITCOMB</i>		15 MOTHER'S MAIDEN NAME First <i>ELIZA</i> Middle <i>F.</i> Last <i>FORMAN</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b SOC AL SECURTY NO. <i>1944-1945</i>		17 INFORMANT <i>MARIAN E. WHITCOMB - SAME AS #13</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i>							
16c1 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Commons Left lung with mediastinal metastasis and pulmonary edema</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 21, 1969</i> , to <i>Jan 23, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 22, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE <i>Horace W. Berninton</i>				22c DATE SIGNED <i>Jan 23, 1969</i>		22d REGISTERAR'S SIGNATURE <i>Charles Judge</i>	
22e. PHYSICIAN'S NAME (Type) <i>HORACE W. BERNINTON</i>				22f. ADDRESS <i>4743 BRADLEY BLVD. CHEVY CHASE, MD.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>1/27/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OLD TENNETT CH. CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>OLD TENNETT, N. J.</i>	
24. FUNERAL DIRECTOR <i>JOS. GAWLER'S SONS, 5130 WIS. AVE, WASH., D.C.</i>		25a. REC'D BY REGISTRAR <i>Jan 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

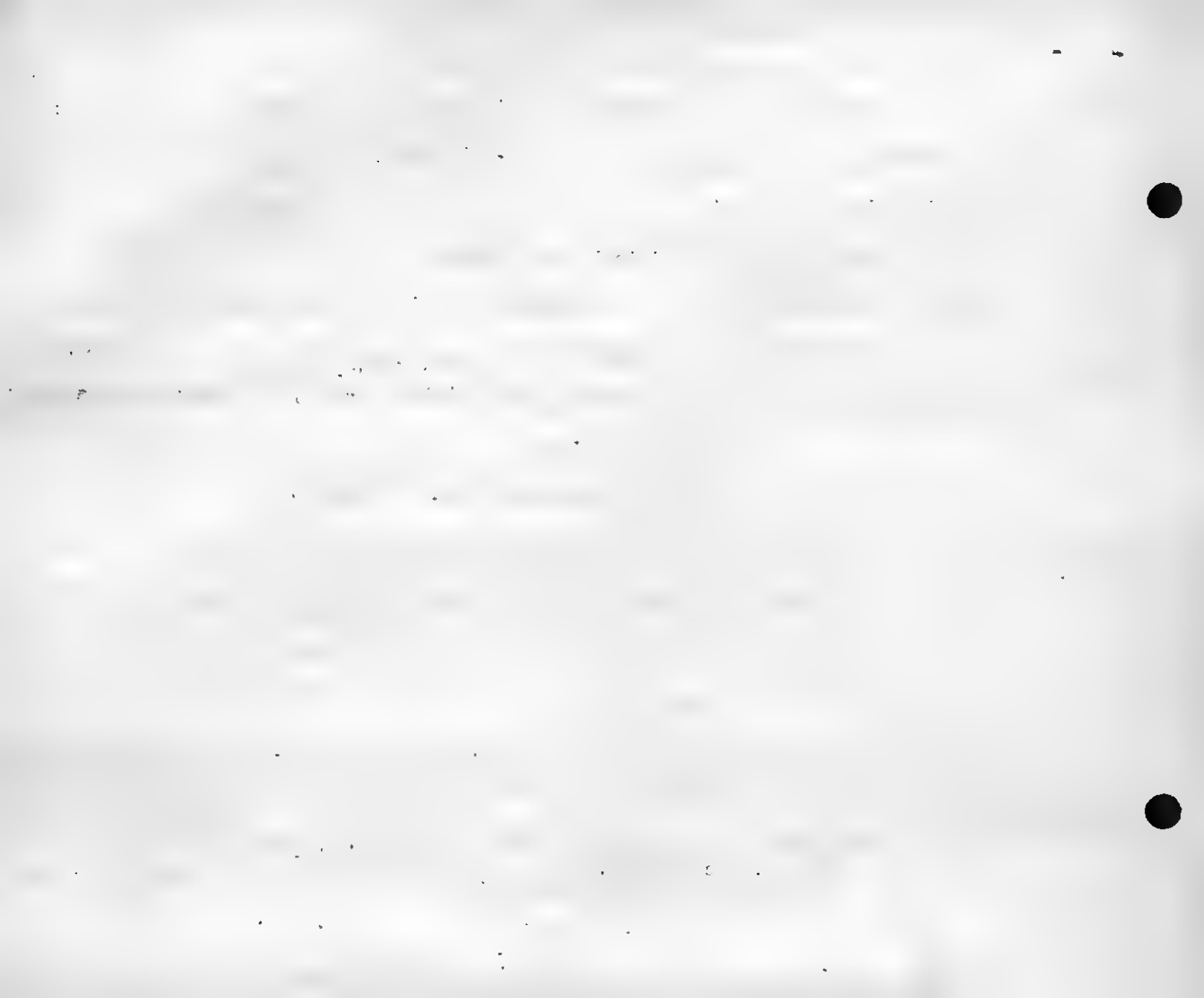
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1275

1. DECEASED NAME (Type or print) First Middle Last Mabel (None) Wiggins			2a. DATE OF DEATH Month Day Year January 3 1969		2b. HOUR AM PM 6:30 AM
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 21 August 1925		6. AGE (In years last birthday) 43 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE District of Columbia	13b. COUNTY District of Columbia	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3507 22nd Street	
14. FATHER'S NAME First Middle Last Flem Mosley		15. MOTHER'S MAIDEN NAME First Middle Last Mamie David			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 578-30-2021		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disseminated Carcinoma of the Cervix DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 10 Months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that the (this hospital) attended the deceased from Dec. 27, 1968 , to Jan. 3, 1969 , that we (we) last saw the deceased alive on January 3, 1969 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, that (we) (did) not view the body after death.					
22b. SIGNATURE Peter J. Deckers MD DEGREE				22c. DATE SIGNED 3 January 1969	
22d. PHYSICIAN'S NAME (Type) Peter J. Deckers, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1/8/69	23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION (City or Town) (County) (State) Red Oak Va	
24. FUNERAL DIRECTOR John T. Rensco - 3015-12 St. NE ADDRESS				25a. REC'D BY REGISTRAR JAN 13 1969	
				25b. REGISTRAR'S SIGNATURE J. Charles George	



CERTIFICATE OF DEATH

1277

01281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) OSCAR LEE WILKERSON			2a. DATE OF DEATH Month 1 Day 7 Year 1969			2b. HOUR 8¹⁰ AM				
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 7-3-08		6. AGE (In years last birthday) 60 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County, Md.				
10. CITY OR TOWN OF DEATH Silver Spring, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 829 BRYANT STREET	
14. FATHER'S NAME First SHELTON W Middle W Last WILKERSON			15. MOTHER'S MAIDEN NAME First OSCAR Middle LEE Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Virginia Wilkerson, 829 Bryant St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia & pleuritis & effusion 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ (Dec 1967)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (3) recent perf. Diabetes mellitus & chronic myocarditis & peptic ulcer										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-6-1965 , to 1-7-1969 , that (I) (we) last saw the deceased alive on 1-6-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE L. F. Longstack M.D.						22c. DATE SIGNED 1-7-69		22d. PHYSICIAN'S NAME (Type)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 10, 1969			23c. NAME OF CEMETERY OR CREMATORY Union Cemetery			23d. LOCATION (City or Town) (County) (State) Bartonsville Montgomery Md.	
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW, Wash DC						25a. REC'D BY REGISTRAR JAN 13 1969		25b. REGISTRAR'S SIGNATURE James J. Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) EVELINE WILLIAMS					2a. DATE OF DEATH Month JAN Day 3 Year 1969			2b. HOUR 12:35 P.M.			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 1/26/83		6 AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) England		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			Md		
10 CITY OR TOWN OF DEATH BETHESDA			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY		13c CITY OR TOWN Chey Chase		13d INSIDE CITY L.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4700 BRADLEY BLVD		
14 FATHER'S NAME First Alfred Middle Stone Last Stone			15 MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO Unknown		17 INFORMANT Daug. Dorothy E. Douse			Address 501 Underwood St, N.W. Washington, D.C.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO VASCULAR COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) Subendocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Dissective Aneurysm Cardinals, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days 20 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1952 to 1/3 , 1967 , that (I) (we) last saw the deceased alive on 1/2 , 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE A. J. O'BRYEN						22c DATE SIGNED 1/3/69		22d PHYSICIAN'S NAME (Type) A. J. O'BRYEN			
22e ADDRESS 4429 Bradley Lane Bethesda, Maryland											
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b DATE 1-6-69			23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d LOCATION (City or Town) (County) (State) Suitland, Maryland		
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a REC'D BY REGISTRAR 1419 9		25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTIN COUNTY DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) <i>Stacie M. Williams</i>						2a. DATE OF DEATH Month <i>January</i> Day <i>16</i> Year <i>1969</i>			2b. HOUR <i>6A</i> M			
3 SEX FEMALE		4 RACE NEGRO		5 DATE OF BIRTH 11-11-1893			6 AGE (In years last birthday) <i>75</i> YRS.		7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8 UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>	
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md						
10. CITY OR TOWN OF DEATH MARTINSBURG			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) UNEMPLOYED			12b KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY MONTG.		13c. CITY OR TOWN MARTINSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER TRUNDLE RD.			
14 FATHER'S NAME First THOMAS Middle WILLIAMS Last WILLIAMS				15 MOTHER'S MAIDEN NAME First NANCY Middle BETTERS Last BETTERS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO			16b. SOCIAL SECURITY NO (If give war or dates of service)		17 INFORMANT MRS. VIOLA WARREN			Address MARTINSBURG, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular disease</i>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. <i>19</i> Month <i>12</i> Day <i>15</i> Year <i>1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No <i>0</i> City or Town <i>Martinsburg</i> County <i>Montg.</i> State <i>MD</i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 15, 1968</i> , 19 <i>52</i> , to <i>Jan 16, 1969</i> , that (I) (we) last saw the deceased alive on <i>Dec 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John S. Lawrence</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>1-20-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>WARREN Church Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Martinsburg Montg. MD.</i>			
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>						ADDRESS <i>Rockville Rd.</i>			25a. REC'D BY REGISTRAR <i>James J. Judge</i>			
						DATE <i>JAN 21 1969</i>			25b. REGISTERED & SIGNED BY			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

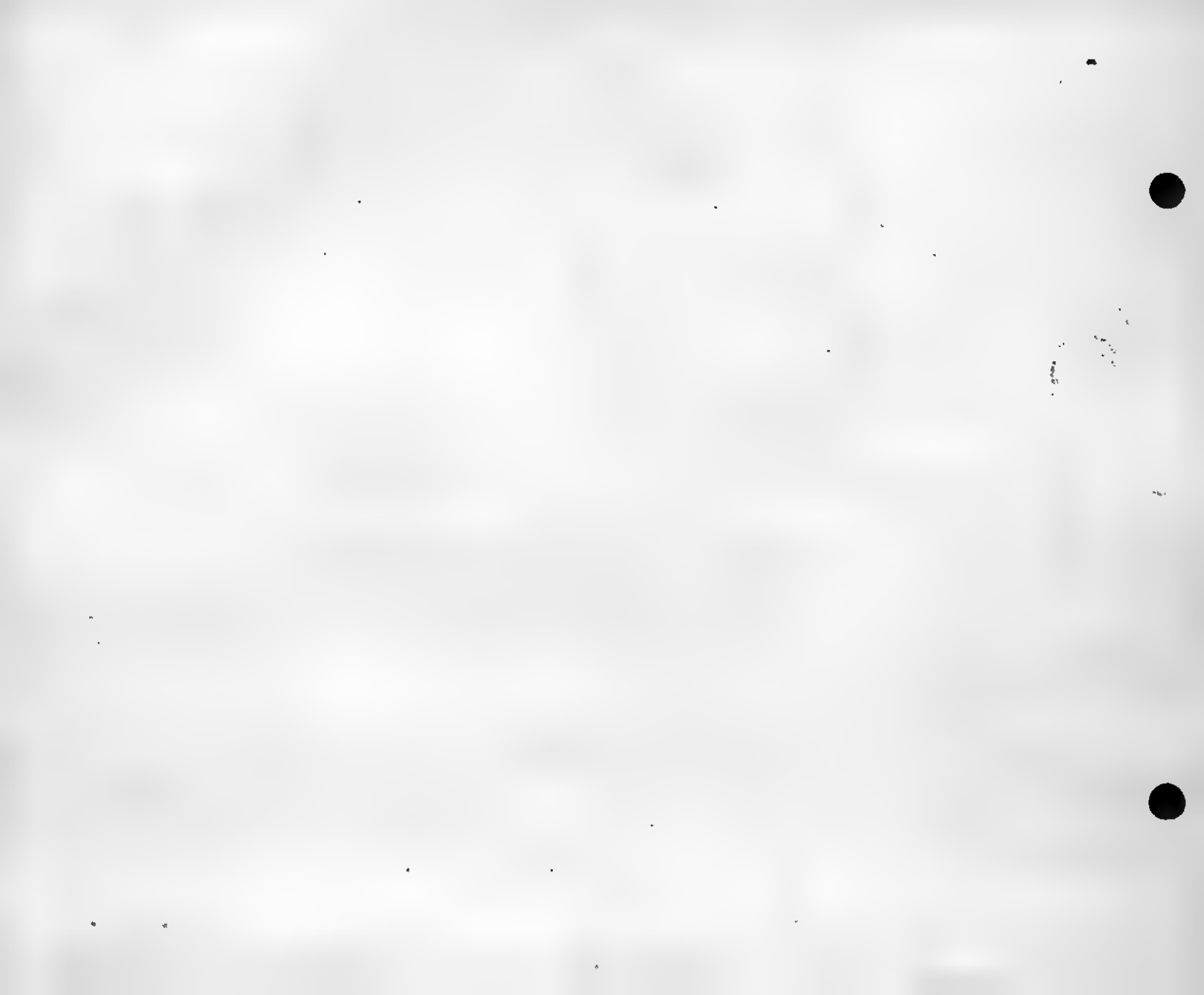
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18-22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-26-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
0128. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01280

1. DECEASED NAME (Type or Print) <i>Margaret Tucker Willier</i>		First Middle Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <i>Jan 24 1969</i> MATED <input type="checkbox"/>		2b. HOUR <i>4:25 P.M.</i>	
3. SEX <i>F</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4-20-13</i>	6. AGE (in years last birthday) <i>55</i> YRS	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <i>Jan 24 1969</i>	
7a. BIRTHPLACE (State or foreign country) <i>Langston</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>11162 Silverwood Lane</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Mc. Tucker School</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission), STATE <i>Montgomery</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INS DE CITY, COUNTY YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>11162 Silverwood Lane</i>		14. FATHER'S NAME First Middle Last <i>Stare M. Tucker</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Julia McPherson</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16b. SOCIAL SECURITY NO		17. INFORMANT <i>John T. Rieck</i>		ADDRESS <i>Samuel</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure due to</i> <i>1500</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Barbiturate intoxication</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ (Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year - HOUR A.M. P.M. <i>1-24 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Deceased took overdose of barbiturate.</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.D. No. City or Town County State <i>Rockville Montg. Md.</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Keap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. KEAP M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City or Town, County) <i>11162 Silverwood Lane</i>		22b. DATE SIGNED <i>JAN. 24, 1969</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-28-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland P. Geo. Md</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>				ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a. REC'D BY REG STRAR DATE <i>JAN 28 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

3-19-69										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1281																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																							
1 DECEASED NAME (Type or Print)					First ADRIENNE					Middle P.					Last WILSON					2a DATE KNOWN OF ESTI DEATH: MATED					X 0-6-69					19					2b HOUR M				
3 SEX F			4 RACE W			5 DATE OF BIRTH 10-25-23			6 AGE (In years last birthday) 45 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			2c DATE PRONOUNCED DEAD Month Day Year					7 6 1969					2d HOUR A P M											
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH Montgomery										Md														
10 CITY OR TOWN OF DEATH Silver Spring					11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 12113 Livingston Street										12a OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY home																			
13a USUAL RESIDENCE (Where deceased admission) STATE					Md.					13b COUNTY Montgomery					13c CITY OR TOWN Silver Spring					3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER 2113 Livingston St.														
14 FATHER'S NAME					First Lawrence					Middle A.					Last Laser					15 MOTHER'S MAIDEN NAME					First Beth					Middle E.					Last Stone				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b SOCIAL SECURITY NO 5-18-22-7623					17 INFORMANT One G. Wilson					ADDRESS Silver Spring, Md. 12113 Livingston Street																								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Deceased, drinking, vomited and aspirated gastric contents DUE TO, OR AS A CONSEQUENCE OF (b) aspirated gastric contents DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b TIME OF INJURY Month, Day, Year HOUR A M P M 1-6 19 69					21c HOW INJURY OCCURRED (Enter nature of injury as Part 1 or Part 2, Item 18) Deceased vomited while drinking and aspirated vomitus.																													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) Home					21f LOCATION Street or R.F.D. No City or Town County State Silver Spring Montg. Md.																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)					Belden R. Reap, M.D. BELDEN R. REAP, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b DATE SIGNED JAN. 6, 1969																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE 1-9-1969					23c NAME OF CEMETERY OR CREMATORY Pahla Cemetery					23d LOCATION (City or Town) (County) (State) Rockville Montgomery Md.																								
24 FUNERAL DIRECTOR M. Andrew Duwall					ADDRESS 1134 E. D. phrey, D.C. 8-131 Georgia Avenue					DATE 10 1969					25b REGISTRAR'S SIGNATURE James J. Jones																								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Richard Alan Wilson			2a DATE OF DEATH Month January Day 6 Year 1969			2b HOUR 2:15 PM					
3 SEX Male		4 RACE White		5 DATE OF BIRTH 27 November 1947		6 AGE (In years last birthday) 21 YRS.		7 UNDER 1 YEAR MONTHS 1 DAYS 1		8 UNDER 24 HRS HOURS 1 MIN 15	
7a BIRTHPLACE (State or foreign country) Indiana		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Radio Technician			12b KIND OF BUSINESS OR INDUSTRY A T & T		
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Florida COUNTY Orange				13c CITY OR TOWN Winter Garden		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Route #1, 170A			
14 FATHER'S NAME First William Middle Wilson Last Wilson			15 MOTHER'S M A DEN NAME First Olive Middle Stone Last Stone								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) --			16b SOCIAL SECURITY NO 264-88-9688			17 INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center,					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Sepsis and Pneumonia due to, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic Myelogenous Leukemia due to, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days 13 Months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that the (this hospital) attended the deceased from 26 November 1968 to 6 January 1969 , that it (we) lost saw the deceased alive on 6 January 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) (did not) view the body after death											
22b SIGNATURE C. H. Brown, III, M.D. DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 6 January 1969			
22d PHYSICIAN'S NAME (Type) C. H. Brown, III, M. D.						22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland.					
23a BURIAL, CREMATION, REMOVAL REMOVAL		23b DATE 1/7/69		23c NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Park Cemetery, Orlando, Orange, Fla				23d LOCATION (City or Town) (County) (State)			
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a REC'D BY REGISTRAR JAN 9 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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VR A 15
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Gilbert M. Wissman</i>						2a. DATE OF DEATH Month <i>10</i> Day <i>22</i> Year <i>69</i>			2b. HOUR <i>11:40</i> M		
3 SEX <i>Male</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH <i>12-23-1887</i>		6 AGE (in years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Elkville Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Silver Spring Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Cathedral Villa Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Household cabinet furniture</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Maker</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>4511 Morgel St.</i>					
14. FATHER'S NAME First <i>Lewis</i> Middle <i>O.</i> Last <i>Wissman</i>				15. MOTHER'S MAIDEN NAME First <i>(Unknown)</i> Middle <i>(Unknown)</i> Last <i>(Unknown)</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY <i>Yes 578-01-</i>		17. INFORMANT <i>Gilbert M. Wissman, Jr.</i>		Address <i>Rockville, Md. 4511 Morgel St.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Pulmonary Edema</i> <i>436.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arterio-Sclerosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2</i> <i>3 months</i> <i>4 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Artero-Sclerotic Heart Disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>12/19</i> , 19 <i>68</i> , to <i>12/22</i> , 19 <i>69</i> , that (I) (we) saw the deceased alive on <i>12/19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Francis X. Richardson</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>FRANCIS X. RICHARDSON</i>				22c. DATE SIGNED <i>1-23-69</i>							
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		23b. DATE <i>1-25-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Pr. Georges, Maryland</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>Sil. Spr., Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>(Signature)</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First JESSE P.			Middle WOLCOTT		Last	
2a. DATE OF DEATH			Month Jan.			Day 28		Year 1969	
3 SEX Male			4 RACE White		5 DATE OF BIRTH March 3, 1893		6 AGE (In years last birthday) 75 YRS		7b. HOUR 8:30 AM
7a. BIRTHPLACE (State or foreign country) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Chevy Chase			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3707 Thornapple St.			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Member of Congress		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3707 Thornapple Street
14 FATHER'S NAME First William			Middle Wolcott			Last			15 MOTHER'S MAIDEN NAME First Lillis B. Paine
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes 1918-1919			16b. SOCIAL SECURITY NO None		17 INFORMANT Mrs. Grace A. Wolcott, Chevy Chase, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral arteriosclerosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>2 days (?)</u> (c) <u>years</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Jan. 24, 1969</u> to <u>Jan. 28, 1969</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>Jan. 24, 1969</u> , and that in (my) <u>(no)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(no)</u> (did) <u>(not)</u> view the body after death.									
22b. SIGNATURE <u>George A. Gray, Jr.</u>				22c. DATE SIGNED 1-28-69				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	
22a. PHYSICIAN'S NAME (Type) GEORGE A. GRAY, JR.				22e. ADDRESS 4740 Chevy Chase Drive Chevy Chase, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-31-69		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
William		Flydd		Wood				ESTIMATED <input checked="" type="checkbox"/> Jan 20 1969		6:55 M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
M	W	Oct 20 1889		79 YRS	MONTHS DAYS		HOURS MIN		Jan 20 1969		6:55 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
Va		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Derwood		7001 Moncaster Mill Rd.		Inspector De Transit		Public Transp.					
13a. USUAL RESIDENCE (Where deceased lived, if in institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY & M 15?		13e. STREET AND NUMBER			
Md		Montgomery		Derwood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7001 Moncaster Mill Rd.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Christopher		R.L.		Wood				Mary		Haines R.W. Hays	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
No				225-01-9742		Lorraine Wood		Sonic 95		13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute - Sudden.											
41124 DUE TO, OR AS A CONSEQUENCE OF											
(b) Cardio Vascular Disease - years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
CAUSE OF DEATH				HOUR A.M. P.M. 9							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John G. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		Jan 20, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1-22-69		Nat'l Memorial Park		Falls Church Virginia					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis H. Barber				Laytonsville, Md. 20760				JAN 22 1969		Francis H. Barber	

18&22a Film 409 Maryland State Department of Health
 2-17-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 11200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01286

FOR STATE
 HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First DONOVAN Donat		Middle STEPHEN	Last Woodmency		2a. DATE KNOWN OF DEATH MATED 1-6-69		2b. HOUR 8:05		
3 SEX Male	4. RACE Wh.	5. DATE OF BIRTH 3-15-1922		6 AGE (In years last birthday) 46RS	IF UNDER 1 YEAR MONTHS 9 DAYS 23	IF UNDER 24 HRS HOURS 7 MIN	2c. DATE PRONOUNCED DEAD Month 1 Day 7 Year 69		2d. HOUR 8:05		
7a. BIRTHPLACE (State or foreign country) NEBRASKA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not a hosp tel give street address) 555 THAYER AVE.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PROFESSOR, BULLS SCHOOL, TEACHER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY Montgom		13c. CITY OR TOWN S. S.		3d. HOME CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 555 THAYER AVE.			
14. FATHER'S NAME		First D.		Middle DALE	Last WOODMENCY		15. MOTHER'S MAIDEN NAME		First VERA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO unavailable		17. INFORMANT MR. FITCH, FITCH & COLE FUNERAL HOME, OMAHA.		ADDRESS NEBRASKA		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis of the liver, extensive 5110 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) extensive DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter: nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION: Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED JAN. 7, 1969	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE JAN. 8/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or Town) Suitland, Maryland		23e. REC'D BY REG. STRAR 20005		23f. HYSOY'S FUNERAL HOME 1300-N. ST., N.W. WASH. D.C.	

1. The first part of the

2. The second part of the

3. The third part of the

4.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 141
45M 2 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Albert P. Woodson</i>			2a. DATE OF DEATH Month <i>Jan.</i> Day <i>8</i> Year <i>69</i>			2b. HOUR <i>11 P.M.</i>	
3 SEX <i>M</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Sept 29, 1893</i>		6 AGE (In years last birthday) <i>75</i>	
7a BIRTHPLACE (State or foreign country) <i>Cal.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>President J.P. Woodson Co.</i>		2b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>7308 Meadow Lane</i>		14 FATHER'S NAME First Middle Last <i>Walter Woodson</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Cecilia Parker</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>522-021-491</i>		17 INFORMANT (Wife) <i>Margaret Woodson Stone</i>		Address <i>Same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute myocardial infarction (anterior & left)</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary arteriosclerosis</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended and deceased from <i>10/67</i> , 19 <i>1967</i> , to <i>1/8/69</i> , 19 <i>1969</i> , that (I) (we) last saw the deceased alive on <i>10/67</i> , 19 <i>1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Henry C. Scruggs MD</i>		22c DATE OF SIGNATURE <i>1/8/69</i>		22d PHYSICIAN'S NAME (Type) <i>Henry C. Scruggs MD</i>		22e ADDRESS <i>5413 Cedarlane Bethesda Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>1-11-1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d LOCATION (City or Town) (County) (State) Md. <i>Suitland, Prince Georges Co.</i>	
24 FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.,</i>				25a REG. BY REG. STAR <i>JAN 13 1969</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	
5130 Wisc. Ave. N.W., Wash., D.C.				DATE			



9.81

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01292

CERTIFICATE OF DEATH

01288

1. DECEASED-NAME (Type or print) Charles W Yoho			2a. DATE OF DEATH Month <u>1</u> - Day <u>2</u> - Year <u>1969</u>		2b. HOUR <u>1:35</u> M
3. SEX MALE	4. RACE white	5. DATE OF BIRTH 3-27-09		6. AGE (In years last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN. <u> </u>
7a. BIRTHPLACE (State or foreign country) W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery County, Md.		
10. CITY OR TOWN OF DEATH Silver Spring Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1718 Vicks Mill Rd.	
14. FATHER'S NAME First Wilbert Middle Yoho Last Yoho		15. MOTHER'S MAIDEN NAME First Nellie Middle ? Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 577-18-8067		17. INFORMANT Address Melva T. Yoho Same as item # 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1533 IMMEDIATE CAUSE (a) CARCINOMA OF SIGMOID COLON WITH DUE TO, OR AS A CONSEQUENCE OF MASSIVE HEPATIC METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 14 MO. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u> </u> <u> </u> <u> </u> <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER, 1967 to JAN. 2, 1968 , that (I) (we) last saw the deceased alive on JAN. 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.					
22b. SIGNATURE Joseph D. Connor M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED January 2, 1968	
22d. PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR, M.D.				22e. ADDRESS 9420 Old Georgetown Rd Bethesda	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/7/1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		23d. LOCATION (City or Town) (County) (State) Rockville, Pike Prince Geo. Md.		25a. REC'D BY REGISTRAR JAN 7 1969	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Tyson, Walter. General Home Bookshelf, 1911.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01289
1. DECEASED-NAME (Type or Print) <i>William Jesse Young</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>Jan 27 1969</i>		2b. HOUR <i>8 1/2 M</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Dec 8, 1922</i>	6. AGE (in years last birthday) <i>66 YRS.</i>	7. IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	8. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD <i>Jan 27 1969</i>		2d. HOUR <i>5 1/2 AM</i>		
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>President & Owner</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-Employ</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3705 Cordiff Rd</i>		
14. FATHER'S NAME First <i>William</i> Middle <i>Jesse</i> Last <i>Young</i>			15. MOTHER'S MAIDEN NAME First <i>Viola</i> Middle <i>Barber</i> Last <i>Barber</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>Not Avail.</i>		17. INFORMANT <i>Son Wm. Young III</i>		ADDRESS <i>Same as above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> <i>953 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hanging with necktie</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>5 min</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>8 1/2 Jan 27 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Hung Self with necktie</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>3705 Cordiff Rd</i>		City or Town <i>Cherry Chase</i>		County <i>Mont.</i> State <i>md</i>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Jan 27 1969</i>		ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-30-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville, Montg. Co. Md.</i>		(County) (State)		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		7557 Wisconsin Ave, Bethesda, Maryland		25a. REC'D BY REGISTRAR <i>FEB 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>				

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